IN THE MATTER OF THE APPLICATION REGARDING CONVERSION OF PREMERA BLUE CROSS AND ITS AFFILIATES

Washington State Insurance Commissioner's Docket # G02-45

REPORT OF

National Economic Research Associates, Inc.

Antitrust and Economic Impact Analysis of the Proposed Conversion of Premera Blue Cross in the State of Washington

November 10, 2003

CONFIDENTIAL and PROPRIETARY
NOT FOR PUBLIC DISCLOSURE

NERA
Economic Consulting

Antitrust and Economic Impact Analysis of the Proposed Conversion of Premera Blue Cross in the State of Washington

Thomas R. McCarthy, Ph.D. and
Scott J. Thomas, Ph.D.
National Economic Research Associates, Inc.

November 10, 2003

Prepared for Premera Blue Cross

Contents

Tables

Figures

Executive Summary

Premera Blue Cross ("Premera") proposes to reorganize from not-for-profit status to for-profit status for the purposes of accessing the equity capital markets. Premera has asked us to evaluate whether the proposed conversion is likely to substantially lessen competition or cause any other adverse economic impacts in the markets in which Premera competes in the state of Washington.[1] To evaluate these issues, there are two key questions that need to be answered. The first question is: Are the markets that Premera competes in competitive in their structure and performance? If they are competitive, then Premera will not be able to increase premiums to consumers or lower reimbursements to providers after the conversion. In such cases competition would continue to constrain Premera's pricing behavior, whether it is a for-profit company or not-for-profit company. The second question is: Does becoming a for-profit company mean that Premera will behave any differently in the markets in which it competes? Clearly, if market conditions impose competitive behavior on all health insurers, Premera will be forced to compete just like the other insurers in its markets in order to garner the normal return on capital needed to stay in business, no matter what its status. In particular, Premera will continue to be focused on financial viability and the conversion will not cause it to pull out of any products, lines of business, or geographic areas that it would otherwise have remained in, even if it were a not-for-profit company.

A. Overview of Antitrust Analysis

We use two different approaches in this report to examine whether the markets that Premera competes in are competitive. Both approaches are directed at determining whether Premera has market power in any of the markets in which it competes.[2] The first approach is an indirect "market structure" approach that involves examining if there are sufficient competitive alternatives in each of the markets to constrain Premera's pricing behavior. If Premera has a very high share in each of the markets, if it faces few competitors in the markets, if entry and expansion are relatively difficult in the markets, *and* if there are no other structural factors that

---

1 We have also been asked to evaluate these same issues for the Alaska Division of Insurance proceedings. We expect to file a separate report for those proceedings.

2 In the context of this case, market power is the ability of Premera to profitably increase its premiums or lower its reimbursement rates on a sustained basis compared to long-run competitive levels by precluding the entry or expansion of competing insurers. This is a long-run concept, and it means that if Premera increases its premiums or decreases its reimbursement rates compared to competitive levels, it would lose relatively little business. Note that market power on the buying side of a market also requires that the quantity of input use decreases as well.

facilitate competition in the markets (such as regulatory oversight or countervailing market power on the other side of the affected markets), this would tend to support the conclusion that Premera has market power (though these indicia are not dispositive given the inferential nature of this approach). The second approach is a direct "competitive effects" approach, which involves comparing Premera's actual performance in each of the markets (in terms of premiums, underwriting margins, and reimbursement rates) to the actual performance found under competitive conditions. If Premera's premiums, underwriting margins, and reimbursement rates are significantly different than those found under competitive conditions, this would tend to support the conclusion that Premera has market power.

1. Market for Health Insurance

In applying the two approaches, we first identify the relevant product and geographic dimensions of all of the markets in which Premera competes. To do so for the health insurance business, we rely upon the principles of demand and supply substitution.[3] Based on these principles, we conclude that the relevant market that Premera competes in on the selling side of the health insurance business is the market for "all health insurance products in the state of Washington." This market includes all PPO and HMO-type products, all fully-funded and self-insured products, all commercial and public lines of business, and all geographic areas in the state (i.e., both Western Washington and Eastern Washington). While there are some differences in our relevant product market and the relevant product markets identified by the Office of Insurance Commissioner's ("OIC's") antitrust consultant Dr. Keith Leffler,[4] these differences are not material to either our conclusion or Dr. Leffler's conclusion regarding whether the health insurance market in Washington is competitive.[5]

---

[3] Intuitively, demand substitution involves determining which other products or services the buyers consider to represent reasonable substitutes for the products or services at issue. Similarly, supply substitution involves determining which other products or services the sellers could readily shift some or all of their capacity from to start producing the products or services at issue.

[4] See Report of Keith Leffler, Ph.D., pp. 18-19 ("I have reached the opinion that there are relevant economic markets for the sale of health care insurance to particular groups, including individuals, the employees and dependents of small employers, and the employees and dependents of large employers, in the state of Washington.")

[5] There are two main differences between our relevant product market and Dr. Leffler's. First, our relevant product market includes all lines of business, whereas Dr. Leffler appears to consider each line of business to represent a separate relevant market. Second, our relevant product market includes both Western Washington and Eastern Washington in a single statewide market, whereas Dr. Leffler appears to believe that these two geographic areas are in separate relevant markets due to the presence of some barriers to entry and expansion.

Having identified the dimensions of the relevant health insurance market that Premera competes in, we then proceed by examining whether Premera has market power in that market. The results of both the indirect and direct approaches support the conclusion that Premera does not have market power on the selling side of the health insurance business in the state of Washington. In particular, the results show:

- Premera has only a 28.4 percent share of the market (based on fully-funded enrollment, the only data available for comparison purposes).
- Premera faces two large competitors (i.e., The Regence Group[6] and Group Health[7]) that offer most of the same products, compete in most of the same lines of business, have roughly the same share of the market, and have shown a willingness to expand geographically when a market opportunity arises.
- Premera faces a number of other competitors including some of the largest insurers in the country (e.g., Aetna, CIGNA, Health Net, Kaiser, and PacifiCare).
- Entry and expansion conditions in Washington appear relatively easy. There have been at least five instances of new entry into the state during the last several years (including Health Net's recent entry into Spokane at the end of 2002), and at least three instances of existing insurers substantially increasing their membership (e.g., Aetna and Molina).
- Premera does not have the ability to increase its premiums to large groups above competitive levels since those groups could readily avoid the premium increase by self-insuring, as well as by switching to rival insurers.
- Premera does not have the ability to increase its premiums to small groups or individuals above competitive levels since there are a sufficient number of competitors and since those lines of business are heavily regulated.
- Premera's premiums are not significantly higher than its competitors, holding constant medical benefits, mix of membership, and inflation.
- Premera's underwriting margins have been in the mainstream of the margins earned by the other health plans that have operated in the state.

---

6 The Regence Group consists of all of the Regence health plans that operate in the State of Washington, including Regence Blue Shield, RegenceCare, Asuris Northwest Health, Regence Blue Cross Blue Shield of OR, and Regence Health Maintenance of OR.

7 Group Health consists of Group Health Cooperative, Group Health Northwest, and Group Health Options (formerly known as Options Health Care).

These results demonstrate that the health insurance market in Washington is competitive. This is the same basic conclusion that Dr. Leffler appears to have reached.[8] While Dr. Leffler also suggests that Premera may have some market power in Eastern Washington, he concludes that regulatory and competitive constraints prevent the exercise of any such power.[9] The regulatory and competitive constraints that Dr. Leffler points to as the reason why Premera is not exercising market power in Eastern Washington are among the same factors that we would point to as the reason why Premera does not have market power in Eastern Washington, even if Eastern Washington were to be considered a separate relevant market.

Dr. Leffler also appears to conclude that the proposed conversion is not going to change the competitive situation.[10] We agree with this conclusion. However, this is the opposite conclusion from the one reached by the OIC's economic impact consultant, PricewaterhouseCoopers ("PwC"). In its report, PwC appears to argue that the conversion together with the implementation of the Dimensions products will somehow enable Premera to increase its premiums above competitive levels to the large groups, small groups, and individuals in Eastern Washington.[11] PwC does not explain how this will occur and its conclusion ignores the competitive realities of the marketplace enumerated above.

---

8 To most economists, a market that produces a competitive outcome is, in effect, competitive. In his report, Dr. Leffler states, "I did not find any evidence that Premera is taking substantial advantage of any market power it may have in setting premiums at this time." [Report of Keith Leffler, Ph.D., pp. 3-4] Thus, Dr. Leffler appears to have concluded that Premera's pricing is constrained and that the market is producing a competitive outcome.

9 *Ibid.*, p. 44 ("I have found evidence that Premera has some market power both in selling insurance and in purchasing providers' services. However, any such market power is limited to Eastern Washington . . . However, the exercise of Premera's market power is constrained by the OIC rate setting rules concerning variation in premiums by area and also by competitive alternatives to Washington registered insurers available to large groups.")

10 *Ibid.*, p. 4. ("The analysis performed in this report is not intended to provide an answer to the question of whether the conversion of Premera to for-profit status may result in higher insurance prices . . . Nonetheless, if Premera continues to compete statewide and if the OIC assures that the variance in individual and small group premiums result only from regional cost differences, then there is little reason to expect any change in the pricing of these policies...For the large groups, Premera can elect to deviate from its traditional premium setting procedures . . . However, any market power with respect to large groups is constrained by the possibility of self insurance and entry.")

11 See PwC's Economic Impact Report, p. ES-8 ("Premera dominates the insurance market in Eastern Washington, with some limited exceptions. Its Dimension product design may allow it to take greater opportunity of its market power in that area."), and p. 95, Table 9-2 (which shows that there will be sizeable premium increases to the individual, regulated small group, small group, and large group lines of business).

2. Markets for Provider Services

Because the second antitrust concern is whether the conversion will allow Premera to reduce reimbursement rates below competitive levels to all providers regardless of type, we focus our attention on the relevant geographic market question for purposes of identifying the relevant markets for provider services. Dr. Leffler uses this same basic approach. Based on our prior experiences in antitrust litigation and merger reviews, our knowledge of prior court cases, and our review of recent studies in the economics literature, we conclude that the relevant markets that Premera competes in on the buying side for provider services are at least as large as Health Service Areas ("HSAs")[12] or Metropolitan Statistical Areas ("MSAs"). Dr. Leffler uses counties as his unit of observation in his statistical analysis examining reimbursement rates.[13] However, as we also explain below, this difference in the geographic extent of the relevant markets does not affect our conclusion as to the competitiveness of the provider markets in Washington.

To examine whether Premera has market power in any of the relevant markets for provider services, we focus our attention on the provider markets in Eastern Washington since it is our understanding that most observers, including Dr. Leffler,[14] agree that provider markets in Western Washington are very competitive. The results of both the indirect and direct approaches support the conclusion that Premera does not have market power. In particular, the results show:

- Premera's share of the total purchase of provider services in Eastern Washington is less than 25 percent (based again on fully-funded enrollment). This result is generally the same whether we look at Eastern Washington as a single provider market or whether we look at the individual HSAs, MSAs, or counties in Eastern Washington.
- Premera's fully-funded large and small group membership in Eastern Washington dropped by nearly 20,000 members between December 2001 and December 2002, indicating competitive losses to rival insurers.

---

12 HSAs represent geographic areas that have been identified using hospital patient flow information for Medicare patients. See, e.g., National Center for Health Statistics, CDC, "Vital and Health Statistics, Health Service Areas for the United States, Series 2: Data Evaluation and Methods Research, No. 112," November 1991.

13 See Report of Keith Leffler, Ph.D., p. 37 ("The hypothesis to be tested is that the average contract claim amount in a county is negatively related to percent of patients that Premera controls in a county.") Note, however, that in another part of his report (pp. 19-20) he says that he is going to consider "metropolitan areas" to represent the relevant geographic markets for provider services.

14 *Ibid.*, p. 23 ("Indeed, in Western Washington, Regence is the largest insurer though neither Regence nor Premera is dominant based on typical economic measures. Therefore, on a priori grounds, there is no expectation that Premera has any ability to control premium levels or provider reimbursements in Western Washington.")

- Premera faces at least five other insurers that have sizeable fully-funded membership in Eastern Washington (i.e., The Regence Group/Asuris, Group Health, Aetna, Community Health, and Molina).
- Premera also faces a number of insurers and third party administrators ("TPAs") that have significant self-insured membership in Eastern Washington (i.e., First Choice, CIGNA, PHCO, and Marsh Advantage).
- The Regence Group/Asuris and First Choice (which is mainly a rental network) both have very competitive provider networks in Eastern Washington. Group Health also has a very strong provider network, particularly in the Spokane area, and Aetna has its own provider network that it is strengthening. Finally, it is our understanding that CIGNA plans to have its own provider network by 2005; currently, it rents the First Choice network.
- Entry and expansion conditions for insurers in Eastern Washington appear relatively easy. There have been at least five instances of new insurers entering Eastern Washington during the last several years (including Health Net's recent entry into Spokane at the end of 2002), and there have been at least four instances of existing insurers gaining substantial membership (i.e., at least 5,000 additional members between 2001 and 2002; CIGNA in large group, Group Health in large group, The Regence Group/Asuris in small group, and Community Health in Medicaid).
- Entry and expansion conditions for physicians in Eastern Washington also appear to be relatively easy. During the 1994 through 2002 period, the number of physicians practicing in Eastern Washington steadily increased from 2,027 in 1994 to 2,549 in 2002. Even though 17 of the 20 counties in Eastern Washington experienced a net increase over the whole period, many of the smaller counties actually experienced decreases from year to year. These findings indicate that the physicians in Eastern Washington are fairly mobile. They also indicate that Premera has not been underpaying the physicians in Eastern Washington since the number of physicians practicing in that area has grown by almost 24 percent.
- Premera must have contracts with a sufficient number of the providers in the rural Eastern Washington counties if it wants to sell to large employers whose employees live outside the counties where their headquarters are located. In many of those counties there are very few providers and, as a result, those providers have considerable negotiating strength. In addition, Washington State law allows the rural hospitals to negotiate collectively with Premera.
- Premera's physician reimbursement rates in Eastern Washington are not significantly lower than its rates in Western Washington, holding constant intensity of service and physician specialty. This is true regardless of whether the analysis is performed on a regional, HSA, MSA, or county level.

These results clearly demonstrate that the relevant provider markets in Eastern Washington are competitive. Premera does not exercise market power as a buyer of provider services. Dr. Leffler's contrary conclusion appears to be based primarily on five findings:[15] (1) that Premera's share of the commercial insurance business in Eastern Washington is much larger than its share in Western Washington, (2) that there are some barriers to entry and expansion in Eastern Washington, (3) that there is a negative and sometimes statistically significant relationship between Premera's reimbursement amounts and its share, (4) that Premera's physician reimbursement rates in Spokane are [ ] percent and [ ] percent lower than the First Choice and Regence rates, respectively, and (5) that the ratios of Premera's area adjustment factors for its Traditional and Prudent Buyer products in Eastern Washington are lower than the corresponding ratios in Western Washington. Our examination of these findings reveals the following:

PROPRIETARY MATERIAL
REDACTED

- Premera's share of the commercial health insurance business is not an appropriate measure to evaluate whether Premera has market power on the buying side for provider services. There are other sources of patients (and reimbursements) besides the commercial patients that providers can turn to if they believe that they were not getting paid enough by Premera. Moreover, as Dr. Leffler acknowledges, high share by itself does not tell whether a firm has market power on the selling or buying side. It merely indicates that additional analysis may be needed.
- Dr. Leffler's barriers to entry and expansion are really only barriers to an insurer quickly becoming as large and well-known as Premera; they are not barriers to preventing a new or existing insurer from effectively constraining Premera's pricing behavior. From the moment a new insurer enters the market, it can be expected to have a competitive effect on premiums as it tries to win business. Moreover, as described above, the actual evidence indicates that entry and expansion conditions in Eastern Washington are relatively easy.
- Dr. Leffler did not have sufficient data to test empirically whether there is a negative and statistically significant relationship between Premera's reimbursement amounts and its share. Using more appropriate available data that includes *allowed* amounts instead of *paid* amounts and controls for the intensity of services associated with each claim, not only causes a dramatic drop in the significant levels, but also causes the sign of the relationship to change. In other words, Premera's share, whether high or low, does not significantly affect the level of reimbursements to providers.

[15] *Ibid.*, p. 4 ("The analysis does support the existence of some market power and some exercise of that market power by Premera in setting reimbursement rates in areas where it has market dominance.")

- Even if Premera does have lower reimbursement rates than First Choice and Regence in Spokane, this is not necessarily evidence that Premera has market power. The lower rates could just reflect that the physicians prefer to deal with Premera since they get paid faster and have fewer administrative hassles – which could also explain why Premera's reimbursements rates are lower than Regence's even in the competitive provider markets in Western Washington. Moreover, larger discounts in return for greater volume is generally considered procompetitive. The economics literature refers to this practice as "selective contracting" and many researchers credit it as one of the major reasons why managed care has helped to control the increase in medical costs.[16]
- The difference in area adjustment factor ratios between Eastern Washington and Western Washington may be just further evidence that providers are willing to grant larger discounts in return for greater volume. There is nothing anticompetitive about this. In addition, a review of Table 3 in Dr. Leffler's report shows that almost half of the difference is due to the area adjustment factor for the Traditional product in Spokane. When the analysis is limited to the non-urban portions of Eastern Washington and Western Washington, the difference in the ratios drops to a point close to zero. Clearly, such a small difference is not compelling evidence of market power.

In addition to concluding that the relevant provider markets in Eastern Washington are currently competitive, we also conclude that the proposed conversion is not going to change this. In contrast, both Dr. Leffler and PwC appear to believe that the conversion, together with the implementation of Premera's Dimensions products, is going to increase Premera's market power in these markets.[17] As evidence, PwC points to the fact that the difference in area adjustment factors between Eastern Washington and Western Washington is expected to increase with the implementation of the Dimensions products. However, PwC apparently does not understand that the change in the area adjustment factors has nothing to do with a reduction in provider reimbursement rates. Instead, it reflects only Premera's expectation that it will be able to channel more of its members in Eastern Washington to the relatively more cost effective providers with its

---

[16] See, e.g., Dranove, David, *The Economic Evolution of American Health Care* (New Jersey, Princeton University Press, 2000), Chapter 4.

[17] See Report of Keith Leffler, Ph.D., pp. 4-5 ("The analysis indicates that Premera has some market power with respect to provider reimbursements in certain regions of Washington. While that market power may be fully exploited under the current regional reimbursement and contracting procedures, such procedures can be changed by Premera to more fully exploit its market power.") and PwC's Economic Impact Report, pp. ES-8-ES-9 ("Premera's market dominance affects its relations with providers, with Eastern Washington providers receiving generally lower payment amounts . . . Geographic area rating factors suggest provider network payments are [ ] in Eastern Washington for the current Premera products and that the difference may increase to [ ] under the Dimensions products.")

PROPRIETARY MATERIAL REDACTED

new, narrowed network product. The Dimensions products are based on a tiering structure where the different tiers reflect differences in provider total health care costs due largely to network composition.

B. Overview of Economic Impact Analysis

Our analysis set forth above explains why the proposed conversion is not going to increase premiums or decrease reimbursement levels compared to competitive, pre-conversion levels. A third possible adverse economic impact that we have been asked to consider is whether the conversion is likely to reduce access to either health insurance products or health care providers. According to the public forums held to discuss the conversion, there is some worry that the conversion will make Premera more concerned about its bottom line and, as a result, Premera might cut back on the lines of business and types of products offered, and/or the geographic areas in which it now sells. To investigate whether the conversion will cause Premera to behave any differently in the markets in which it now competes, we proceed in four steps. First, we examine whether Premera, in the past, has subsidized certain lines of business, geographic areas, and/or products that it felt were not profitable and never would be. Second, we examine whether there are any institutional factors that would prevent Premera from cutting back on its operations, even assuming that the conversion would create *added* pressure on Premera to increase its profits. Third, we discuss previous studies of what has happened in other conversions as a result of health insurers changing from not-for-profit status to for-profit status. Finally, we examine whether the not-for-profit insurers in Washington charge significantly lower premiums than the for-profit insurers, holding constant medical benefits, mix of membership and inflation.

The results of our analysis demonstrate that the conversion is not going to change Premera's behavior in the markets in which it competes and therefore will not reduce access.[18] Specifically, the results show that Premera in the past has focused on the bottom line and has offered only those products and services that make commercial sense. It has done so due to competitive pressures. For example, during the last several years, Premera has cut back significantly on the counties in which it offers certain lines of business (i.e., Healthy Options and

[18] Note that these results directly contradict the assumption in both the Leffler report and the PwC report that Premera's behavior will automatically change if it converts from not-for-profit status to for-profit status. Neither the Leffler report nor the PwC report provides any theoretical or empirical evidence to support their assumption. Moreover, economic theory predicts that not-for-profit firms may behave either differently or the same as for-profit firms. The answer depends in part on the goals of the organization and on the constraints imposed by the competitive environment in which they operate.

Basic Health Plan), and it has stopped offering other lines of business (e.g., Medicare managed care and Public Employees Benefit Board in 2004) and certain products (e.g., HMO products) altogether. Our results also show that, even though Premera has cut back significantly on the counties in which it offers certain lines of business, it is very unlikely that it would stop serving those counties altogether, for several good business reasons. First, Premera considers its large provider network to be one of its competitive strengths and it uses that advantage to compete for members, particularly with large multi-site employers that have employees located throughout the state. Second, there is some risk that Premera could be challenged on the rights to its Blue Cross or Blue Shield marks in any "abandoned" county if it does not provide a full network that can be used by Blue plans in other states when those out-of-state Blue plans sell a promise of national coverage to a multi-state company headquartered in their state. Also, it is very unlikely that Premera would ever pull out of the large group, small group, and individual lines of business in the state altogether since the Health Insurance Portability and Accountability Act ("HIPAA") would prevent it from re-entering any of those lines of business for five years. The results further show that studies done for the proposed CareFirst and BCBS of North Carolina conversions found that past conversions have not had any meaningful effect on accessibility. Finally, our statistical analysis finds that the not-for-profit insurers in Washington have behaved no differently than the for-profit insurers, at least with respect to premiums. This finding is consistent with competition forcing all insurers, whether for-profit or not-for-profit, to compete aggressively for business by keeping premiums low and keeping expenses in check.

C. Conclusions

The proposed conversion is not going to "substantially lessen competition or tend to create a monopoly in the health coverage business" in the state of Washington. The relevant markets that Premera competes in for health insurance and for provider services are competitive. The conversion is not going to change this. In particular, the conversion is not going to cause premiums to increase or reimbursement rates to decrease compared to competitive levels.

The proposed conversion is also not going to reduce consumer access to health insurance products or health care providers any more than it would if Premera were to remain a not-for-profit. Premera has been concerned about its financial viability, and it will continue to offer only those products and services that make commercial sense because competitive forces drive health plans to manage costs and keep premiums at competitive levels. In addition, Premera will continue to contract with health care providers in rural counties since it considers its large

provider network to be one of its competitive strengths and it uses that advantage to compete for members, including the large multi-site employers that have employees located throughout the state.

I. Introduction

National Economic Research Associates, Inc. ("NERA") is a global firm of consulting economists founded in 1961. We have nine offices in the United States, four in Europe, one in Tokyo, one in Sao Paulo, and one in Sydney. NERA economists analyze competitive, regulatory, and public policy issues in a wide variety of industries, including the health care industry. Dr. Thomas R. McCarthy and Dr. Scott J. Thomas are health economists in NERA's Los Angeles office.

Dr. McCarthy is a Senior Vice President of NERA. He also serves as head of NERA's health care practice in the U.S. Dr. McCarthy holds a B.A. degree in economics from Assumption College in Worcester, Massachusetts, and M.A. and Ph.D. degrees in economics from the University of Maryland. For the last twenty-five years, he has specialized in the study of industrial organization and health economics, focusing principally on antitrust and competitive issues in the health care marketplace, as well as on intellectual property issues involving medical devices. His work also includes the study of health insurance reform. He is co-editor and a principal author of a two-volume study of health reform around the world entitled, *Financing Health Care*. Dr. McCarthy has testified in a variety of antitrust cases relating to health care provider services and health care insurance markets. He has also made presentations to state and federal antitrust agencies and to a state insurance commission on the likely competitive effects of a wide range of health care provider mergers, health plan mergers, and medical device company mergers being reviewed by those agencies. Recently, he was invited by the Federal Trade Commission and the Department of Justice Antitrust Division to testify at three separate sessions of their Joint Hearings on Antitrust in Healthcare. Those sessions included testimony on potential monopoly problems and monopsony problems in health insurance markets. Prior to joining NERA, Dr. McCarthy worked as a Staff Economist for the Federal Trade Commission in Washington, D.C., and as an Assistant Professor of Economics at the School of Economics and Management of Oakland University in Michigan, where he taught, among other courses, health economics. A more complete listing of his qualifications, publications, and prior testimony is provided in his curriculum vitae found in Appendix A-1.

Dr. Thomas is a Vice President of NERA. He holds a B.A. degree in economics from the University of California, Los Angeles, and M.A. and Ph.D. degrees in economics from the University of California, Irvine, where his areas of concentration included industrial organization

and econometrics. Dr. Thomas has published several articles on economic theory and econometrics in refereed journals, and has also written several articles for the American Bar Association on health care antitrust matters. During the thirteen years that he has worked at NERA, Dr. Thomas has provided written and/or oral testimony in a variety of health care cases involving a number of different health care settings, including hospitals, physicians, insurers, trauma centers, rehabilitation services, and medical equipment manufacturers. He has also made several presentations regarding the likely competitive effects of provider mergers to state and federal antitrust authorities. Prior to joining NERA, Dr. Thomas held a teaching position at the University of California, Irvine, where he lectured on economic theory. A more complete listing of his qualifications, publications, and prior testimony is provided in his curriculum vitae found in Appendix A-2.

In this matter, Premera Blue Cross ("Premera") proposes to reorganize from not-for-profit status to for-profit status for the purposes of accessing the equity capital markets. Premera has asked us to evaluate whether the proposed conversion is likely to "substantially lessen competition or tend to create a monopoly in the health coverage business" in the state of Washington.[19] In doing so, we focus our attention both on the output market, where Premera competes against other commercial insurers and third party administrators to sell health insurance policies and services to employers and consumers, and on the input market, where Premera competes against other commercial insurers and other payers to purchase health care services from physicians and hospitals. In particular, we examine whether the proposed conversion is likely to increase health insurance premiums in the output market or reduce reimbursement rates in the input market compared to competitive levels.[20] We have also been asked to examine whether the proposed conversion is likely to reduce consumer access to either health insurance products or health care providers, or to cause any other adverse economic impacts. Finally, we have been asked to comment on the recently submitted reports of the Office of Insurance Commissioner ("OIC") economic consultants, Dr. Keith Leffler and PricewaterhouseCoopers ("PwC").

---

19 RCW 48.31C.030 (5) (a) (ii).

20 There are at least two ways that this could occur. The first way is that the proposed conversion could somehow create or enhance Premera's market power on either the selling side or the buying side of the respective markets. This might result in an increase in health insurance premiums or a reduction in provider reimbursement rates compared to competitive levels. The second way is that the proposed conversion might somehow cause Premera to exercise existing market power that it previously had not been exercising due to its nonprofit status. This could also result in an increase in health insurance premiums or a reduction in provider reimbursement rates from the levels at which they otherwise would have been. We investigate both possibilities in this report.

We have reviewed a variety of materials in performing our work. These include Premera's overview of its operations, strategy, and rationale for the conversion, Premera's business plan, the reports of the OIC consultants, and many of the documents produced by Premera to the OIC consultants. The materials also include many confidential and proprietary documents that we requested from Premera, such as competitor assessments, disenrollment studies, win/loss data, physician contracting presentations, and physician reimbursement data. Additionally, the materials include various items obtained from publicly available sources, such as the annual filings and Form B filings obtained from the OIC, the Washington Hospital Association managed care information, the Interstudy HMO and PPO enrollment data, and the HealthLeaders managed care reports. In addition, we have interviewed a number of Premera's senior managers and several brokers in Eastern Washington. A list of all of the materials that we have relied upon is found in Appendix A-3.

The remainder of the report is organized as follows. Section II provides important background information concerning the products and lines of business that Premera offers, the rationale for the conversion, and the regulatory environment. Sections III and IV present our formal analysis of whether the proposed transaction is likely to "substantially lessen competition or tend to create a monopoly in the health coverage business" in the state of Washington. In Section III, we examine whether the proposed conversion is likely to increase premiums to consumers above competitive levels. This requires us to identify the (product and geographic) dimensions of the relevant health insurance market that Premera competes in as a seller and to evaluate whether Premera has market power in that market. In Section IV, we investigate whether the proposed conversion is likely to reduce reimbursement rates to providers from the levels found under competitive conditions. This requires us to identify the dimensions of the relevant provider markets that Premera competes in as a buyer and to determine whether Premera has market power in any of those markets. Section V presents our formal analysis of whether the proposed conversion is likely to reduce consumer access to either health insurance products or health care providers, or to cause any other adverse economic impacts. In section V, we examine whether the proposed conversion is likely to cause Premera to cut back on the lines of business and the types of products offered, and/or the geographic areas in which it now sells. Finally, in Section VI, we provide some concluding remarks.

II. Background Information

Premera represents the merger of two independent Blue plans headquartered in Western and Eastern Washington: Blue Cross of Washington and Alaska and the Medical Services Corporation of Eastern Washington.[21] Blue Cross of Washington and Alaska began selling health insurance in Washington in 1948. It held the Blue Cross "mark" in all of Washington (except for Clark County) and the Blue Cross and Blue Shield "marks" in all of Alaska. The Medical Services Corporation of Eastern Washington began selling health insurance in Eastern Washington in 1933. It held the Blue Shield mark in fourteen counties in Eastern Washington. The two Blue plans affiliated in 1994 and merged in 1998. The merged corporation is named Premera Blue Cross. Today, the company operates as Premera Blue Cross in all of Washington (except for Clark County) and as Premera Blue Cross Blue Shield in fourteen counties in Eastern Washington. An affiliate of Premera operates as LifeWise in every county in Washington.

Premera currently competes in a broad range of commercial and public lines of business. These include the large group, small group, individual, Public Employees Benefit Board ("PEBB"), Federal Employee Health Benefit ("FEHP"), Medicaid managed care, Basic Health Plan ("BHP"), and Medicare Supplement lines of business. Premera competed in the Medicare managed care business, but like many other insurers nationwide, decided to exit that business in 2002 due primarily to inadequate funding by the federal government. Premera currently offers a wide range of fully-insured and self-funded products to its customers, including preferred provider organization ("PPO"), point of service ("POS"), indemnity, and Medicare supplement products.[22] It sells these products in every county in the state of Washington.[23] If Premera were to pull out of the individual, small group, or large group business in the state as a whole, it would not be able to re-enter that line of business for five years due to provisions in federal statutes.[24]

Premera currently has one of the largest provider networks in the state. It has contracts with physicians in every county[25] and it also contracts with every hospital in the state but one.[26]

---

21 See Premera Exhibit E7 to the Form A Filing, October 25, 2002, specifically "Overview of New Premera Operations and Strategy and Rationale for Conversion," pp. 6 and 8-9.

22 See Premera Exhibit E7 to the Form A Filing, October 25, 2002, specifically "Overview of New Premera Operations and Strategy and Rationale for Conversion," p. 16. According to its website and Interstudy, Premera also offers an HMO product but that product is being phased out.

23 See Premera response to OIC Request # E432A.

24 Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Sections 2712 and 2742.

25 See Premera response to OIC Request # E516.

Although most of Premera's contracted physicians have standard contracts, a large number of them also have negotiated contracts.[27] All of Premera's contracted hospitals have negotiated contracts. All of the physician and hospital contracts that Premera has executed are terminable upon short notice by either party and none of them include a most-favored-nation ("MFN") clause.[28] One of the unique characteristics of Washington is that the state has passed a collective bargaining law for the rural hospitals. This law allows the rural hospitals to join together when negotiating reimbursement rates with Premera and the other insurers.[29]

A primary rationale for the conversion is Premera's desire to access the equity capital markets to increase statutory reserves, provide for growth, and make investments in infrastructure and technology.[30] Premera expects that the greater certainty of being able to meet its future financial obligations will make it a stronger company. In addition, Premera's current reserves are considered relatively low compared to most other Blue plans. The conversion is intended to improve this situation. Although the conversion will result in Premera reorganizing from nonprofit status to for-profit status, the conversion is not expected to change the company's tax status in the state of Washington. Even as a nonprofit company, Premera must pay a two percent tax on its premiums. The conversion is not expected to change this tax rate. In 2001, Premera paid nearly $36 million in premium taxes to the states in which it operates.[31]

PROPRIETARY MATERIAL REDACTED

---

26 See Premera file "PBC Hospitals WAOnly.xls."

27 PROPRIETARY MATERIAL REDACTED

28 An MFN clause typically guarantees an insurer that no other insurers will get better reimbursement rates than it gets. It has been argued that MFN clauses can sometimes represent a barrier to entry since, if a new insurer tried to enter by obtaining lower reimbursement rates from providers than the existing insurers, the providers would also have to provide those lower rates to their existing insurers. Thus, the providers would be less likely to enter into a contract with a new insurer at low reimbursement rates.

29 RCW 70.44.450.

30 See Premera Exhibit E7 to the Form A Filing, October 25, 2002, specifically "Overview of New Premera Operations and Strategy and Rationale for Conversion," p. 19.

31 *Ibid*, p. 7.

32 Premera document titled "Form A Combined Financial Projections and Assumptions," Bates No. 0016047. We have not reviewed the financial data included in the three-year planning tool recently presented to the Premera Board of Directors and provided to the OIC staff. As such, we have not determined the impact, if any, of this data.

PROPRIETARY MATERIAL REDACTED

From a licensing and regulatory point of view, there are three types of health insurers in the state of Washington: Health Care Service Contractors ("HCSCs"), disability carriers, and Health Maintenance Organizations ("HMOs").[37] The first two types of insurers are licensed to sell indemnity and PPO-type products, and can also sell HMO look-a-like products. The third type of health insurer is licensed to sell HMO products, which allow the insurer to share some portion of the insurance risk with providers. All three types of health insurers are regulated by the OIC. At one time, Premera, through an affiliate, held an HMO license; however, that affiliate merged into Premera and therefore Premera no longer has an HMO licensed affiliate. Through several affiliate entities, Premera currently holds HCSC licenses, and life and disability licenses.

For a company to enter and obtain a license to sell health insurance products in Washington, it must meet certain regulatory requirements.[38] First, the company must demonstrate

---

33 *Ibid,* Bates No. 0016053.

34 *Ibid,* Bates No. 0016051.

35 *Ibid,* Bates No. 0016053.

36 *Ibid,* Bates No. 0016053.

37 See, e.g., www.insurance.wa.gov/special/coverwashington/answers/rateincreases.asp.

38 In addition to having to meet these regulatory requirements, a new entrant would also have to establish business operations in the state. This generally includes hiring sales and administrative staff, renting office space, obtaining

that it has a minimum net worth and sufficient funded reserves.[39] If a company is a health plan already operating outside or inside Washington, the net worth requirement necessary to enter or expand in the Washington market is likely to have been satisfied. Second, there are filing requirements involving the company's rates and contracts. As discussed below, the specific filing requirements differ according to the line of business that the company is entering. Finally, a company must also demonstrate that it has "adequate" provider networks to serve its members.[40] The network adequacy requirement creates a strong incentive for plans to maintain broad networks to avoid the additional costs associated with being declared an "inadequate network."[41] This requirement is often harder to satisfy in those rural areas where providers may be in short supply. In such areas, plans generally face competition among providers and it is harder to ensure that contracted providers are available to members. This sometimes creates a situation in which the insurer will have to agree to pay a contracted provider higher reimbursement rates than it otherwise would have in order to ensure coverage.

The small group and individual businesses in Washington are subject to significant regulation by the state.[42] For example, all small group and individual rates and contracts must be filed with the OIC prior to use. Small group rates are subject to requirements related to the filing process, method of development, and amount. They must (1) be filed with the OIC before they are used, (2) based on adjusted community rating (i.e., no experience rated underwriting is allowed for a specific small group), and (3) not be unreasonable in relation to the amount charged.[43] The Commissioner may disapprove rates not meeting these criteria. Just like small group rates, individual contract rates are subject to requirements related to the filing process,

---

a provider network through contracting with physicians and hospitals or by "renting" an existing network from other insurers (such as First Choice or Private Healthcare Systems), and establishing relationships with insurance agents, brokers and consultants.

39 For example, to become an HSCS, a company "must have and maintain a minimum net worth equal to the greater of: (a) Three million dollars; or (b) Two percent of the annual premium earned ... on the first one hundred fifty million dollars of premium and one percent of the annual premium on the premium in excess of one hundred fifty million dollars." [RCW 48.44.037]

40 WAC 284-43-200 Network Adequacy ("a carrier should not require travel of thirty miles or more when a provider who meets carrier standards is available for inclusion in the network and practices within five miles of enrollees").

41 For example, in the event a plan is deemed to have an inadequate network and a member is forced to obtain care from a non-network provider, the plan can be required to increase the payment it would otherwise make to the provider in order that the member can receive the care "at no greater cost to the covered person than if the service were obtained from network providers . . ." [WAC 284-43-200 Network Adequacy]

42 The large group business in Washington is also regulated, but the OIC rarely disapproves negotiated rates. [See, e.g., www.insurance.wa.gov/special/coverwashington/answers/rateincreases.asp.]

43 RCW 48.44.020(3).

method of development, and amount. They must (1) be filed with the OIC before they are used, (2) based on adjusted community rating, and (3) be reasonably expected to result in a loss ratio that meets or exceeds the minimum loss ratio standard set by the legislature of 74 percent, less applicable premium tax rate.[44] The Commissioner may disapprove rates not meeting these criteria. Insurers are not allowed to medically underwrite small groups or individuals. However, most individuals must fill out a standard, state-defined medical questionnaire when applying for individual coverage. Anyone scoring above a defined threshold can be denied coverage. If denied coverage, the individual is then eligible for the state's high-risk pool. The state's high-risk pool is heavily subsidized by assessments on the state's insurers, including Premera.

[44] RCW 48.44.017(3)(d).

III. The Proposed Conversion Will Not Increase Premiums

This section begins our formal analysis of whether the proposed conversion is likely to "substantially lessen competition or tend to create a monopoly in the health coverage business" in the state of Washington. Specifically, we examine whether the health insurance market is competitive and whether the proposed conversion is likely to cause premiums to increase above competitive levels by changing this situation.

Two important issues must be analyzed to determine whether the proposed conversion is likely to increase premiums above competitive levels. First, and most importantly, is the market for health insurance in Washington competitive in its structure and performance? If it is, then Premera cannot raise premiums after the conversion, and competition will continue to constrain Premera's pricing, whether it is a for-profit company or a not-for-profit company. Clearly, if market conditions impose competition on all health insurers, Premera will be forced to compete just to garner the normal return on capital needed to stay in business, no matter what its status.

If the market is not competitive, then we would analyze a second issue – whether becoming a for-profit company means that Premera would behave differently in the market for health insurance. The economics literature suggests that not-for-profits may not behave any differently with respect to their pricing, even in the absence of competition.[45] The intuition behind this observation is that not-for-profit firms may, in some instances, want to maximize profits, just like a for-profit company, perhaps so that the profits can then be used to pursue the not-for-profit's mission. Thus, it is not clear that a conversion would change pricing behavior, even if a lack of competition allowed it.

There is substantial evidence that Premera has been forced by competition to behave as a profit maximizer just like the other carriers in the Washington market, both not-for-profit and for-profit. While we discuss below the issue of not-for-profit behavior compared to for-profit behavior, that issue is largely moot since we find that competition drives pricing in the health insurance market in Washington. Thus, we concentrate mainly on an analysis of competition in this report.

---

[45] See, e.g., W. Lynk, "Property Rights and the Presumptions of Merger Analysis," *The Antitrust Bulletin* (Summer 1994), pp. 363- 383; see also J. Simpson and R. Shin, "Do Nonprofit Hospitals Exercise Market Power?" *International Journal of the Economics of Business* Vol. 5, No. 2 (1998), pp. 141-157.

A. Premera Does Not Have Market Power on the Selling Side of the Health Insurance Market

In an antitrust context, market power on the selling side of a market is the ability of a firm to raise the price or lower the quality of its product on a sustained basis and to earn long-run profits above competitive levels by precluding the entry and expansion of competitors.[46] Economists generally use two basic approaches to evaluate whether a firm has market power on the selling side. The first approach is an indirect "market structure" approach that involves identifying the relevant market in which the firm competes, determining the firm's share of that market, examining entry and expansion conditions for competitors, and evaluating other structural factors that could facilitate or hinder competition (such as the presence of large, sophisticated buyers). If the firm has a substantial share of the market, if it faces few competitors, if the entry or expansion of competitors is difficult, *and* if there are no countervailing structural factors, this generally supports the inference that the firm may have market power (though these indicia are not dispositive given the inferential nature of this approach).

The second approach that is used to evaluate whether a firm has market power is a direct "competitive effects" analysis that involves comparing the actual performance of the firm in question to the performance of comparable firms producing the same relevant product that operate under competitive conditions. If the firm's transaction prices and profits are significantly greater on a sustained basis than those of the comparable firms, this could indicate that the firm in question has market power and has been able to raise prices to supracompetitive levels. In this matter, we use both the indirect and direct approaches to evaluate whether Premera has market power on the selling side of the health insurance market in the state of Washington. We conclude that Premera does not have market power and, therefore, the relevant market is competitive in both its structure and its performance.

1. The Relevant Market

To analyze competitive conditions, we must first identify all of the health insurance products and companies that might effectively constrain Premera's pricing behavior. The market that contains all of these products and companies is known as the *relevant market*. By definition, a relevant market contains both product and geographic dimensions. The role of the *relevant*

[46] Many economists refer to this type of significant market power as monopoly power. It is a long-run concept, and it means that if the firm increases its prices above the competitive level, the firm would lose relatively few customers and, thus, successfully monopolize the market.

product market is to describe the product or service dimensions of the relevant market. It should include all of those products and services that are good demand and supply substitutes and, thus, effectively constrain Premera's pricing behavior. Likewise, the role of the *relevant geographic market* is to describe the spatial boundaries of the relevant market. It should include all of the health insurance companies at all of their locations that are good demand and supply substitutes for Premera and, thus, can competitively constrain the pricing of Premera's products.

a. The Relevant Product Market

Economists generally use the principles of demand and supply substitution to determine the *relevant product market*.[47] On the demand side, this means that the market should include all of those health insurance products that buyers could reasonably turn to if the price of their particular type of insurance coverage rises to levels that these buyers feel are no longer competitive. For instance, an employer may choose to contract with a gatekeeper PPO instead of the HMO now under contract if the HMO raises premiums too much relative to the premiums of the PPO product.[48] Similarly, on the supply side, this means that the market should include all of those health insurance products that existing insurers could either start offering or expand their presence in if the price of the products now being purchased were to rise above competitive levels. For instance, an insurer that is currently offering only an HMO product may choose to leverage its provider network and start offering a PPO product if other insurers raise their PPO premiums so much that a market opportunity arises for the HMO.[49]

(1) Demand Substitution

From a demand substitution standpoint, there are two main questions: (1) Are HMO-type products good demand substitutes for PPO-type products? and (2) Are self-funded products good demand substitutes for fully-funded products? To answer these questions, economists typically examine employer product offerings, insurer disenrollment data, insurer win/loss data, insurer proposal data, and broker spreadsheets. We examined all of these types of data and determined that HMO products are good demand substitutes for PPO products, and that self-insurance is a

---

47 See, e.g., D. Carlton and J. Perloff, *Modern Industrial Organization* 3rd ed. (New York: Addison-Wesley, 2000), pp. 612-615.

48 Likewise, an employer may choose to self-insure instead of contract with an insurer for fully-funded products if the insurer raises premiums too much.

49 Likewise, an insurer who is currently only competing in the small group business may decide to enter the large group business if other insurers raise their large group premiums too much.

good demand substitute for fully-funded insurance. However, there is no need to detail our analysis here since the OIC's antitrust consultant, Dr. Leffler, has also concluded that all of these products are good demand substitutes for each other and should be included in the same relevant product market.[50] This means that the only remaining product market question is whether the different lines of business should be included in the same relevant product market or whether they should represent separate relevant product markets. To answer this question, as well as to confirm Dr. Leffler's finding regarding the PPO and HMO-type products, we will turn to the principle of supply substitution.

(2) Supply Substitution

To determine which health insurance products and lines of business are good supply substitutes, economists typically examine insurer product offerings, insurer lines of business, regulatory and business conditions for insurers expanding their operations, and actual evidence of expansion into new products and new lines of business. The information about the product offerings shows that most of the major insurers in Washington offer PPO-type products as well as HMO-type products. [See Table 1.] For example, the information shows that Premera, Regence, and Aetna all offer indemnity, PPO, POS, and HMO products.[51] Likewise, the information shows that CIGNA, First Choice, and PacifiCare all offer PPO and HMO products. Finally, the information shows that Kaiser, PacifiCare, and One Health all offer POS and HMO products. Given that the major insurers already offer most of the products at issue, this supports the conclusion that all of these products are good supply substitutes for each other since the insurers could leverage their existing operational structure and provider networks to readily shift capacity between the different products if the economic incentive created by a move to monopoly pricing were to arise.

In addition to the major insurers offering most of the health insurance products, they also compete in most of the different lines of business. For example, the information about the different lines of business shows that Premera, Regence, Group Health, Aetna, PacifiCare, Kaiser, and KPS all compete in the large group and small group lines of business, while Premera,

---

50 See Report of Keith Leffler, Ph.D., p. 19 ("For large employers, such self insurance belongs in the relevant product market") and p. 19, footnote 61 (where he cites the *Marshfield Clinic* case for the proposition that PPO products should be in the same relevant product market as HMO products).

51 Note that Premera has stopped selling new HMO policies and is in the process of converting its HMO members over to its other products, including an HMO look-a-like product.

Table 1: List of Products for Selected Washington Health Insurers, 2003

Insurer	Traditional Indemnity	PPO	POS	HMO
Aetna	x	x	x	x
Community Health				x
CIGNA		x	x	x
First Choice		x	x	x
Group Health			x	x
Kaiser			x	x
KPS	x	x		
Molina				x
One Health		x	x	x
PacifiCare		x	x	x
Premera	x	x	x	x
Regence	x	x	x	x

Note: First Choice has announced plans to exit the commercial insurance business by the end of 2003.

Sources: Company websites, "'Seattle, Washington, HealthLeaders Market Overview, Research," HealthLeaders, Inc., February 2003, and First Choice Health Network Annual Report, 2002.

Regence, Group Health, and KPS all compete in the individual line of business.[52] [See Table 2.] Likewise, many of these insurers also compete in the state employee and federal employee programs in Washington. Finally, many of these insurers also compete in the Medicaid managed care program in Washington, and have competed in the Medicare managed care program when it was profitable to do so. Thus, this information supports the conclusion that these different lines of business are good supply substitutes for each other since insurers could readily shift capacity between them if they wanted to.

The regulatory and business conditions further support the conclusion that it would not be difficult for an existing insurer to start offering a new product or to expand into a new line of business. As mentioned above, once an insurer has been licensed in the state, the insurer would have already met the minimum net worth requirement. Likewise, if an existing PPO insurer wanted to begin offering a POS or an exclusive provider organization ("EPO") product, the

[52] While Aetna, PacifiCare, and Kaiser report individual membership, the OIC website indicates that only Premera, Regence, Group Health, and KPS are actively marketing individual products at this time.

Table 2: Lines of Business for Selected Washington Health Insurers, 2002

Insurer	Individual	Small Group	Large Group	Basic Health Plan	Public Employees (PEBB)	Federal Employees (FEHB)	Medicaid Managed Care	Medicare Managed Care	Medicare Supplement
Aetna	x	x	x	x	x	x	x		
Columbia United				x			x		
Community Health				x	x		x		
First Choice			x						x
Group Health	x	x	x	x	x	x	x	x	
Kaiser[1]	x	x	x	x	x	x		x	
KPS	x	x	x			x			x
Molina				x			x		
One Health		x	x						
PacifiCare	x	x	x		x	x		x	
Premera[2]	x	x	x	x	x	x	x		x
Providence		x	x						
Regence	x	x	x	x	x	x	x	x	x
United HealthCare			x						

[1] The Centers for Medicare and Medicaid Services reported that Kaiser did not offer a Medicaid Managed Care product, while Kaiser's annual statement shows a positive net premium for that line of business.
[2] Based on Premera's 2002 annual statement, it did not renew Medicare managed care contracts in 2002.

Sources: Health Insurer Annual Statements, December 31, 2002, http://www.insurance.wa.gov/special/coverwashington/answers/market_share_analysis.doc, http://www.insurance.wa.gov/publications/consumer/Medicare_Choice2002.pdf, and http://cms.hhs.gov/medicaid/managedcare/mmcss02.asp.

insurer could do so by utilizing its existing operational structure and provider networks. In addition, even though an existing PPO insurer may not wish to build the required provider network for offering a traditional HMO product (given the market's general disenchantment with HMOs), the insurer could readily offer an HMO look-a-like product (e.g., an EPO product) without much difficulty. Finally, other than having to meet the filing requirements, it is our understanding that it is not difficult for an existing insurer to expand into a new line of business.

Recent examples of existing insurers offering new products or expanding into new lines of business include: PacifiCare offering a PPO product in 2002 after already offering both commercial and Medicare HMO products;[53] Regence marketing a defined contribution plan in June 2001 to self-insured employers with at least 50 employees after already offering a variety of fully-funded products;[54] Aetna marketing a defined contribution health plan to large and mid-size self-insured companies in September 2001 after already offering commercial and Medicaid HMO products;[55] First Choice expanding into the Medicare managed care business in 1998 after already

53 HealthLeaders, *Market Overview, Seattle, Washington, February 2003*, p. 18.

54 HealthLeaders, *Market Overview, Seattle, Washington, April 2002*, p. 18.

55 HealthLeaders, *Market Overview, Seattle, Washington, April 2002*, p. 19.

competing in the large group, small group, and individual businesses;[56] and, First Choice offering an HMO product in 1997 after already offering a PPO product.[57]

(3) Conclusion

In summary, the available information in this case supports the conclusion that the appropriate relevant product market for examining the likely competitive effects of the proposed conversion is the market for "all health insurance products." This market includes all indemnity and PPO-type products as well as all HMO-type products. It also includes all fully-funded products and all self-insured products. Finally, it includes all commercial lines of business (i.e., the large group, small group, individual, state employee, and federal employee lines of business) as well as all public lines of business (i.e., Medicare managed care, Medicaid managed care, Medicare Supplement, and Basic Health Plan lines of business).

This relevant product market differs from the ones identified by Dr. Leffler's in one respect: it includes all lines of business, whereas Dr. Leffler appears to believe that each line of business represents a separate relevant product market.[58] The reason for this difference is that the method that Dr. Leffler used to identify his relevant product markets is based on demand substitution only and does not account for the ability of the insurers to shift some or all of their capacity from one line of business to another, assuming that the economic incentive for such a shift were to arise. As we explain below, although our relevant product market does differ from the relevant product markets identified by Dr. Leffler, this difference is not material to either our conclusion or Dr. Leffler's conclusion regarding whether the health insurance market in Washington is effectively competitive. We both find that the market produces a competitive outcome.[59]

---

56 Gartner Group, *Healthcare Market Overview: Seattle, Washington,* December 1999, p. 18.

57 CJ Singer – A Gartner Group Company, *Managed Care Market Overview: Seattle-Tacoma-Bremerton, WA,* September 1997, p. 2.

58 See Report of Keith Leffler, Ph.D., pp. 18-19 ("I have reached the opinion that there are relevant economic markets for the sale of health care insurance to particular groups, including individuals, the employees and dependents of small employers, and the employees and dependents of large employers, in the state of Washington.")

59 To most economists, a market that produces a competitive outcome is, in effect, competitive. In his report, Dr. Leffler states, "I did not find any evidence that Premera is taking substantial advantage of any market power it may have in setting premiums at this time." [Report of Keith Leffler, Ph.D., pp. 3-4] Thus, Dr. Leffler appears to have concluded that the market is producing a competitive outcome.

b. The Relevant Geographic Market

Economists also generally use the principles of demand and supply substitution to determine the *relevant geographic market*. However, in the case at hand, demand substitution is not much of an issue since there are no available data about how far consumers will travel to purchase health insurance. In general, brokers, agents, and consultants bring product offerings to the employers. Moreover, these middlemen are very efficient at finding insurance coverage opportunities on behalf of their clients. They are rarely restricted to only those insurers with local provider networks, especially since insurers lacking a local network can establish one or rent an existing one if the market opportunity arises. Thus, supply substitution is the more important issue in analyzing geographic markets. Insurers that are currently operating outside of a given location may be able to readily enter that location and start offering competing products if the economic incentive were to arise. If this were the situation, then any insurer already in the area in question would not be able to raise its premiums above competitive levels without causing insurers from other geographic areas to enter and bid the premiums back down to competitive levels. As a result, virtually all the health insurers in all geographic areas of the state would generally be considered good supply substitutes for each other and therefore should be included in the same relevant geographic market.

(1) Supply Substitution

To determine which insurers in which geographic areas are good supply substitutes for each other, economists also typically examine the regulatory and operational conditions required for expansion as well as the actual evidence of expansion. As mentioned above, once an insurer has been licensed to operate in the state, the regulatory conditions required for it to expand its operations from one part of the state to another are minimal. This is because the insurer will have already met the minimum net worth and filing requirements and because the provider network adequacy requirement can be met by offering acceptable contracts to providers. In addition, the operational conditions required for expansion are not difficult since most established insurers have already borne many of the fixed costs needed to expand[60] and since there are at least two statewide provider networks in Washington that can be rented as a vehicle for geographic expansion (i.e., First Choice and Private Healthcare Systems).

---

[60] For example, most insurers would not have to set up a new claims processing site since they typically use a single location to process all of their medical claims for any given state.

Given that the regulatory and operational conditions required for expansion are not difficult, it is not surprising that there have been a large number of examples of expansion in Washington over the last several years. This includes at least four insurers who already had existing operations in Western Washington expanding their operations into other parts of Western Washington (such as NYLCare in 1997 and Providence in 2000). [See Table 3.] It also includes at least four insurers who had existing operations in Western Washington only expanding their operations into Eastern Washington (such as the predecessor to the Regence Group in 1995 and

Table 3: List of Health Plans Expanding into Eastern or Western Washington, 1995 – 2002

	Year	Parent Name	Plan Name	Plan Type	Existing Region	New Region(s)
(1)	1995	King County Medical[1]	Walla Walla Valley MSC	na	Western Washington	Eastern Washington
(2)	1997	NYLCare	NYLCare Health Plans Northwest	HMO	Western Washington [Seattle MSA]	Western Washington [Olympia and Tacoma MSAs]
(3)	1998	First Choice	First Choice Health Network	PPO	Western Washington	Eastern Washington
(4)	1998	Regence	Regence Northwest Health	PPO	Eastern Washington	Eastern Washington [Spokane Area]
(5)	1998	NYLCare[2]	NYLCare Health Plans Northwest	HMO	Western Washington	Eastern Washington [Spokane MSA]
(6)	1998	NYLCare[2]	NYLCare Health Plans Northwest	HMO	Western Washington	Western Washington [Bremerton MSA]
(7)	1999	NorthwestOne[3]	NorthwestOne	PPO	Western Washington	Eastern Washington [Spokane County]
(8)	2000	Group Health	Group Health Cooperative	HMO	Eastern and Western Washington	Eastern Washington [Kittitas, Walla Walla, and Whitman Counties]
(9)	2000	Group Health	Group Health Cooperative	HMO	Eastern and Western Washington	Western Washington [Clallam, Grays Harbor, Lewis, Mason, San Juan, and Skagit Counties]
(10)	2000	Sisters of Providence	Providence Health Plan of Oregon	HMO	Western Washington [Clark County]	Western Washington [Cowlitz, Pacific, and Wahkiakum Counties]
(11)	2001	Group Health	Group Health Cooperative	HMO	Eastern and Western Washington	Eastern Washington [Columbia County]
(12)	2001	Molina	Molina Healthcare of Washington	HMO	Eastern and Western Washington	Western Washington [Cowlitz County]
(13)	2001	Sisters of Providence	Providence Health Plan of Oregon	HMO	Western Washington	Western Washington [Skamania County]
(14)	2002	Aetna	Aetna U.S. Healthcare Inc. (a Washington corporation)	HMO	Western Washington	Western Washington [Kitsap and Lewis Counties]

Notes: "na" indicates information is not available.

Based on Interstudy data, for expansions into a new county only those plans that have an enrollment increase of more than 300 members are considered expansions.

[1] The Regence Group, through its predecessor King County Medical Blue Shield, expanded into Eastern Washington by acquiring Walla Walla Valley Medical Service Corp., which later became Regence Northwest Health (i.e., Asuris).

[2] NYLCare was subsequently acquired by Aetna in July 1998.

[3] NorthwestOne, created by KPS Health Plans in 1998, is primarily a rental network that has some self-insured business.

Sources: Col. (1): Charles J. Singer & Co., "Managed Care Market Overview: Seattle-Tacoma-Bremerton, WA," February, 1995, page 10.
Col. (2): Interstudy HMO MSA Profiler, 1996-1998.
Col. (3): Gartner Group, "Healthcare Market Overview: Seattle, Washington," December 1999, p. 18.
Col. (4): Spokane-Area Health-Care Plans, Journal of Business 2001 Book of Lists, December 7, 2000, p. 68.
Cols. (5) - (6): Interstudy HMO MSA Profiler, 1996-1998.
Col. (7): Ruth Levine, "NorthwestOne pushes across the Cascades," *Puget Sound Business Journal*, July 5, 1999, http://seattle.bizjournals.com/seattle/stories/1999/07/05/newscolumn3.html.
Cols. (8) - (14): Interstudy HMO by County, 1999-2001.

First Choice in 1998). Finally, it includes at least two insurers who already had existing operations in Eastern Washington expanding their operations into other parts of Eastern Washington (such as the Regence Group in 1998 and Group Health in 2000 and 2001).

(2) Conclusion

In summary, the available information supports the conclusion that it is relatively easy for existing insurers to move from one part of the state to another. This means that the appropriate relevant geographic market for evaluating the likely competitive effects of the proposed conversion on the health insurance business is the state of Washington as a whole. This relevant geographic market includes both Western Washington and Eastern Washington.

As in the case of the relevant product market, Dr. Leffler appears to differ with us on the extent of the relevant geographic market.[61] In particular, he appears to believe that Western Washington and Eastern Washington are in separate relevant geographic markets due in part to the presence of some barriers to entry and expansion.[62] Dr. Leffler does not address any evidence of actual entry or expansion in his report, some of which we discussed above.[63] Although we appear to differ with Dr. Leffler in the extent of the relevant geographic market, this difference is not material to either our conclusion or Dr. Leffler's conclusion regarding whether the health insurance market in Washington is competitive, since we both find that it is, in effect, competitive.[64]

---

61 The OIC's economic impact consultant, PwC, also appears to disagree with us on the extent of the relevant geographic market for the health insurance business. In its report, PwC appears to believe that each county represents a separate relevant geographic market since it is assuming that Premera has market power in every county in which it has a greater than 65 percent share of the fully-funded commercial health insurance business. [See PwC's Economic Impact Report, pp. 92 and 95.] PwC does not explain in its report how it came up with this geographic market determination.

62 See Report of Keith Leffler, Ph.D., p. 44 ("I have found evidence that Premera has some market power both in selling insurance and in purchasing providers' services. However, any such market power is limited to Eastern Washington. The evidence that Premera has some market power in selling insurance in Eastern Washington includes Premera's high market shares and the presence of some barriers to entry and expansion by competitors.")

63 We will discuss Dr. Leffler's barriers to entry and expansion in the next section of this report.

64 As mentioned earlier, most economists consider a market that is producing a competitive outcome to be competitive. In his report, Dr. Leffler states, "I did not find any evidence that Premera is taking substantial advantage of any market power it may have in setting premiums at this time." [Report of Keith Leffler, Ph.D., pp. 3-4] Thus, Dr. Leffler appears to have concluded that the market is producing a competitive outcome.

2. Indirect Approach: Analysis of Market Structure

a. Market Concentration

Table 4 summarizes the shares for all of the insurers that have operated in Washington during the period 1997 through 2002.[65] The shares are based on the enrollment in fully-funded products for the state as a whole as of December of each year.[66] Although, ideally, the enrollment of members in the self-insured products should be included as well, that information is not

Table 4: Market Shares for Washington Health Insurers, Based on Enrollment, 1997 – 2002

Insurer	1997	1998	1999	2000	2001	2002
Premera	26.2 %[1]	24.4 %	25.7 %	27.7 %	29.2 %	28.4 %
Regence	29.4	28.6	29.6	26.8 [2]	25.6	27.2
Group Health	16.7	16.0	15.9	17.4	19.2	19.5
Community Health	1.5	1.6	4.1	5.9	6.4	7.0
Molina	-	-	-	2.5	4.4	5.4
PacifiCare	4.6	4.6	4.4	5.1	4.5	4.0
Kaiser	2.5	2.6	2.9	2.9	2.8	2.8
KPS	2.2	2.1	1.4	1.2	1.4	1.5
Aetna[3]	1.1	4.1	4.1	3.1	2.8	1.5
First Choice	0.8	1.1	1.8	2.1	1.6	1.0
One Health	-	0.1	0.2	0.5	0.4	0.2
Providence	3.7	4.5	0.4	0.4	0.2	0.1
United HealthCare	na	0.0	0.8	0.4	0.0	-
Others	11.3	10.2	8.6	4.0	1.5	1.4
Total	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**

Notes: Figures reflect all fully-insured business in the state of Washington except for the dental and vision business.
Figures do not include disability insurers that offer health insurance. In particular, enrollment for CIGNA is not available since CIGNA offers its health product through its subsidiary, Connecticut General Life.
"na" indicates that the health plan existed but information was not available for that year.
"-" indicates that the health plan was not available in that year.

[1] 1997 enrollment for Premera is adjusted to include enrollment for MSC, which merged into Premera in 1998.

[2] 2000 figure for Regence does not include data for Northwest WA Medical Bureau, which Regence acquired in Novmber 2000.

[3] 1998 figure includes enrollment for NYLCare, which Aetna acquired in 1998.

---

65 The figures in this table differ from the ones in Table 5-1 of the PwC report in several respects. First, PwC did not include the HMO Washington (now RegenceCare) enrollment and the Walla Walla Valley (now Regence Northwest/Asuris) enrollment in the Regence Group total enrollment for 1997, whereas we did. Second, PwC did not include the Options Health Care enrollment in the Group Health enrollment from 1997 to 1999, whereas we did. Finally, PwC excludes the United enrollment in 1999 and 2001 and the HealthGuard Services enrollment in 1999 to 2001 but includes their enrollment in the other years. We include their enrollment in all years.

66 The shares based on the premiums of the fully-funded products provide similar results as those based on total premiums in that they show that Premera has never had more than a 27.1 percent share of the business and that the Regence Group and Group Health have always been strong competitors. [See Table B-1 in Appendix B.] In fact, the shares based on premiums suggest that Group Health has been an even stronger competitor, i.e., Group Health's share based on premiums is 27.1 percent in 2002, whereas its share based on enrollment is only 19.5 percent in 2002.

publicly available in most instances.[67] The table shows that, during the period in question, Premera has never had more than a 29.2 percent share of the fully-funded business. The table also shows that, during this same period, Premera's share has fluctuated from a low of 24.4 percent in 1998 to a high of 29.2 percent in 2001 and then back down to 28.4 percent in 2002. Fluctuations in shares are generally evidence of the ebb and flow of competitive activity. The table further shows that, during the period in question, The Regence Group[68] and Group Health[69] have both always had a sizeable share of the fully-funded business and that their shares have also fluctuated from year to year. Finally, the table shows that, during this same period, Premera has always faced a number of other competitors including some of the largest insurers in the country (e.g., Aetna, CIGNA, Kaiser, PacifiCare, and United HealthCare). Given that Premera has never had more than a 29.2 percent share, given that The Regence Group and Group Health have both always had a sizeable share of the business, given that Premera has always faced a sizeable number of other competitors, and given that the shares of all of the insurers have fluctuated from year to year, these factors support the conclusion that Premera does not have market power.

As explained above, the different lines of business do not represent separate relevant markets by themselves since insurers can readily shift their capacity from one line of business to another. However, even if one were to disagree with our conclusion, the available information still supports the conclusion that Premera does not have market power. This is because Premera does not have a dominant share in any of the lines of business and because Premera faces a number of competitors in each line of business. For example, Table 5 shows that, based on the premiums for fully-funded products as of December 2002, Premera's share of the individual, small group, and large group lines of business equaled 47.0 percent, 34.8 percent, and 38.3 percent, respectively. Table 5 also shows that Premera faced at least seven competitors in each of those lines of business[70] and that together those three lines of business comprised about 57 percent of the total market only, with the individual line of business being responsible for only 4.8 percent of the total market. Finally, Table 5 shows that, in the remaining 43 percent of the market,

---

67 The Form B filings contain only a limited amount of information about enrollment for self-funded products.

68 The Regence Group consists of all of the Regence health plans that operate in the state of Washington, including Regence Blue Shield, RegenceCare, Asuris Northwest Health, Regence Blue Cross Blue Shield of OR, and Regence Health Maintenance of OR.

69 Group Health consists of Group Health Cooperative, Group Health Northwest, and Group Health Options (formerly known as Options Health Care).

70 Note that the OIC website reports that there are only four insurers in Washington that are actively marketing individual policies.

Table 5: Shares of Washington Health Insurers by Line of Business, Based on Premiums, 2002

Insurer	Individual	Small Group	Large Group	Basic Health Plan	Public Employees (PEBB)	Federal Employees (FEHB)	Medicaid Managed Care	Medicare Managed Care	Medicare Supplement	Other
Premera	47.0 %	34.8 %	38.3 %	13.1 %	12.4 %	27.3 %	11.6 %	0.1 %	50.2 %	3.0 %
Regence	33.3	51.2	26.6	16.3	11.5	21.8	6.7	0.5	46.6	89.7
Group Health	13.5	5.9	24.1	13.6	52.9	33.7	6.8	44.3	-	-
PacifiCare	0.1	0.4	3.5	-	9.4	2.5	-	45.8	-	1.7
Community Health	-	-	-	46.9	1.2	-	26.3	-	-	-
Kaiser	4.0	3.1	3.1	3.1	3.0	6.0	0.4	9.3	-	5.6
Molina	-	-	-	2.2	-	-	38.2	-	-	-
KPS	1.7	2.1	1.8	-	-	6.6	-	-	2.7	-
Aetna	0.5	2.1	1.1	1.0	9.5	2.0	1.4	-	-	-
Columbia United	-	-	-	3.7	-	-	8.6	-	-	-
First Choice	-	-	1.4	-	-	-	-	-	0.5	-
Providence	na	na	na	na	na	-	-	-	-	-
One Health	-	0.3	0.0	-	-	-	-	-	-	-
United HealthCare	-	-	0.0	-	-	-	-	-	-	-
Total	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**
Percent of Total Health Insurance	**4.8 %**	**11.9 %**	**40.5 %**	**4.8 %**	**5.4 %**	**6.6 %**	**9.4 %**	**12.5 %**	**2.7 %**	**1.4 %**

Notes: Figures reflect all fully-insured business in the state of Washington.
Figures do not include disability insurers that offer health insurance.
CIGNA offers its health product through its subsidiary, Connecticut General Life.
"na" indicates that the health plan existed but information was not available for that year.
"-" indicates that the insurer did not offer a product in that market segment.

Source: Private insurers' annual statements filed with the OIC for the year ending December 31, 2002.

Premera had only a 12.6 percent share of the business. Thus, this information further indicates that Premera does not have market power.

b. Entry and Expansion Conditions

In assessing entry and expansion conditions, economists often proceed in two steps. The first involves investigating whether there are any significant barriers in the market, while the second involves looking at the actual experience in the market. As discussed earlier, there do not appear to be any significant barriers to expansion or new entry into the health insurance business in any part of Washington. Neither the regulatory requirements nor the operational requirements are difficult to overcome, especially for an insurer that is already operating in another state or one that plans to enter Washington by utilizing one of the two existing statewide provider rental networks. Moreover, the regulatory and operational requirements do not appear to favor the existing insurers that are already operating in Washington.[71] Finally, the available information indicates that at least five new insurers have entered the state during the last several years –

[71] Although it would likely cost a significant amount of money for a new insurer to enter the state, economists typically would not consider this to represent a true barrier to entry. Most economists consider a barrier to entry to represent only those additional costs that the incumbent firm(s) did not have to incur.

although one of these insurers (Molina) entered as a result of purchasing an existing insurer and then chose to concentrate on the Medicaid managed care product line. [See Table 6.] All of the above indicates that Premera does not have market power since new insurers could readily enter if Premera tried to raise its premiums above competitive levels.

Table 6: List of Health Insurers Entering Washington, 1995 – 2002

	Year	Parent Name	Plan Name	License Type
(1)	1995	UnitedHealth Group	United HealthCare of Washington	HCSC
(2)	1996	First Choice	First Choice Health Plan	HCSC
(3)	1997	Great West	One Health Plan of Washington	HCSC
(4)	2000	Molina	Molina Healthcare of Washington	HMO
(5)	2002	Health Net	USelect	HCSC

Sources: Col. (1): "Managed Care Market Overview, Seattle-Tacoma-Bremerton, WA," CJ Singer, May 1996, p. 8; and "United HealthCare Completes MetraHealth Acquisition," UnitedHealth Group News Release, October 3, 1995.
Col. (2): "Managed Care Market Overview, Seattle-Tacoma-Bremerton, WA," CJ Singer, 1995, p. 8 [http://www.fchn.com/fch/about/index.html].
Col. (3): "New Health Insurance Carrier to Receive Certificate of Authority From Washington State," PR Newswire, August 15, 1997.
Col. (4): Interstudy HMO by County, 1999 - 2000, and "QualMed of Washington Announces Its New Name - Molina Healthcare of Washington," Business Wire, July 17, 2000.
Col. (5): "Success of USelect Plan in Spokane, Wash., Leads Vivius and Health Net to Launch USelect in 14 Additional U.S. Markets." Business Wire, May 27, 2003.

Similarly, as mentioned above, there do not appear to be any significant barriers for existing insurers to expand their operations in Washington. The regulatory and operational requirements are minimal and there are plenty of examples of the insurers actually expanding their operations. Such expansion has occurred in several forms: (1) insurers adding additional members to its existing products and lines of business, (2) insurers adding additional products and/or lines of business, and (3) insurers serving additional parts of the state. The last two types of expansion have already been discussed. With respect to the first type of expansion, the available information shows that at least three insurers have been able to add a sizeable amount of members very quickly. For instance, Molina grew from 79,003 members in 2000 to 134,059 members in 2001. [See Table 7.] Likewise, Community Health Plan grew from 54,700 members in 1998 to 128,938 members in 1999. Finally, Aetna grew from 37,224 members in 1997 to 136,432 members in 1998 – although a large amount of this growth was due to Aetna's

Table 7: Enrollment for Health Insurers in Washington, 1997 – 2002

Insurer	1997	1998	1999	2000	2001	2002
Premera	881,519 [1]	818,121	813,571	889,046	881,967	839,455
Regence	988,713	957,730	937,593	860,970 [2]	773,271	805,775
Group Health	561,965	534,754	504,832	558,957	580,872	577,702
Community Health	48,980	54,700	128,938	189,121	193,492	208,378
Molina	-	-	-	79,003	134,059	160,839
PacifiCare	154,993	154,923	139,345	164,637	135,901	118,182
Kaiser	83,993	88,072	91,325	92,470	84,995	83,238
KPS	74,119	71,730	45,130	40,032	42,656	44,837
Aetna[3]	37,224	136,432	128,523	100,989	84,396	43,490
First Choice	27,228	36,821	56,764	68,670	47,758	28,715
One Health	-	3,568	7,799	15,074	12,873	5,781
Providence	125,036	150,584	14,135	13,619	4,541	2,172
United HealthCare	na	635	24,842	14,045	111	-
Others	381,097	342,955	273,221	128,595	45,649	42,278
Total	**3,364,867**	**3,351,025**	**3,166,018**	**3,215,228**	**3,022,541**	**2,960,842**

Notes: Figures reflect all fully-insured business in the state of Washington except for the dental and vision business.
Figures do not include disability insurers that offer health insurance. In particular, enrollment for CIGNA is not available since CIGNA offers its health product through its subsidiary, Connecticut General Life.
"na" indicates that the health plan existed but information was not available for that year.
"-" indicates that the health plan was not available in that year.

[1] 1997 enrollment for Premera is adjusted to include enrollment for MSC, which merged into Premera in 1998.

[2] 2000 figure for Regence does not include data for Northwest WA Medical Bureau, which Regence acquired in Novmber 2000.

[3] 1998 figure includes enrollment for NYLCare, which Aetna acquired in 1998.

Source: Washington State Hospital Association, "Profile of Washington State Health Plans," Fall 1998 to 2003 Reports.

acquisition of NYLCare. This information further supports the conclusion that Premera does not have market power since existing insurers could readily expand their operations if Premera tried to raise its premiums above competitive levels on any line of business in any part of the state.

In his report, Dr. Leffler argues that there are four barriers to entry and expansion that would in theory make it difficult for insurers to constrain Premera's pricing behavior in Eastern Washington. The barriers that he identifies are (1) the costs to employers of switching carriers, (2) the cost to an entrant of establishing an attractive network of providers, (3) the costs of establishing a reputation comparable to that of Blue Cross/Blue Shield, and (4) the legal requirements to market health insurance in the state of Washington.[72] Most economists consider an economic barrier to entry to represent only those additional costs that a new entrant firm would have to incur that the incumbent firm did not.[73] By this definition, none of these four alleged barriers represent a "true" economic barrier since each of them simply reflects the costs associated

[72] See Report of Keith Leffler, Ph.D., p. 17.

[73] See, e.g., D. Carlton and J. Perloff, *Modern Industrial Organization* 3rd ed. (New York: Addison-Wesley, 2000), pp.76-77.

with becoming as large and well-known as Premera in Eastern Washington, i.e., they only represent the same costs that Premera has had to incur in competing for membership. Moreover, to a large extent, these costs are not one-time expenses. All of these costs reflect continuing investments in (1) trying to win and keep new members, (2) maintaining provider networks, (3) providing good service to members and providers to maintain a strong reputation and (4) continuing to meet the state's legal requirements, such as rate filings, network adequacy, risk-based reserve levels, disclosures to members, etc.

Dr. Leffler argues that the most important of the barriers to entry is switching costs. In particular, he says, "Employers indicate that they are very reluctant to switch insurance plans if their employees do not retain full access to the doctors that they are accustomed to seeing."[74] If all else is equal, this argument sounds correct; why switch for no gain? However, whether switching costs really represents a barrier to entry depends on the premium savings that the employers could obtain by switching if a firm were to attempt monopoly pricing. Moreover, insurers compete, in part, by setting up broad provider networks with substantial physician overlap to minimize any switching costs that members might face if forced to find a new physician. First Choice, for example, has a broad network of physicians in Eastern Washington as an alternative. Through our interviews with brokers, we have been told that brokers can get employers to switch carriers so long as they can deliver to the employers at least a five percent savings in premiums for small groups and closer to a 10 percent savings for large groups. The brokers in Eastern Washington indicate that their market is very price sensitive. Moreover, Premera regularly loses business when its rate increases exceed the rates offered by its rivals.[75]

Also, if Premera really had a significant advantage in Eastern Washington due to high switching costs and the attractiveness of its provider network, we would expect Premera's membership in Eastern Washington to remain fairly constant over time. We would not expect

---

74 Report of Keith Leffler, Ph.D., p. 3.

75 There is ample documentary support on win-loss data, disenrollment data, proposal activity, and sales tracking reports. All of these data show clear evidence of competition over accounts and willingness of companies to switch for even modest savings. For example, a March 2002 Disenrollment Report by Premera states [PROPRIETARY MATERIAL REDACTED] Premera document titled "Group Disenrollment Research, Summary – January – December 2001, Market Research Department, March 2002," p. 4] Similarly, a sales tracking tool for the sales department in Eastern Washington shows recent examples of small group cancellations during mid-2003. The comment section of the table shows that [PROPRIETARY MATERIAL REDACTED] Companies will switch carriers; it happens all the time. [See Dimensions New Sales Tracking Tool for 2003.]

Premera to lose (or even gain) significant membership year to year. However, account activity data reported in Premera's Business Decision Reports, 2002 database show that Premera regularly loses existing accounts and wins new ones in both regions of the state. Table 8 shows that, for 2002 (statewide), Premera had [ ] fully-funded large group accounts that cancelled. These contracts covered over [ ] members. During the same time, Premera lost over [ ] members in small group accounts (1-50 employees) and won over [ ] new large group and small group accounts covering more than [ ] members. As shown in the table, at least [ ] accounts renewed during 2002. These renewed contracts covered over [ ] members. This is clearly a substantial amount of turnover. Many companies are switching. On a percentage basis, for the large and small groups combined, cancelled contracts in 2002 accounted for [ ] percent of all contract activity while new contracts accounted for [ ] percent. Only [ ] percent of all contract activity was for renewal business during a single year. Given competitive conditions with

PROPRIETARY MATERIAL REDACTED

Table 8: Premera Account Activity, Number of Groups and Members that Cancelled, Signed Up, or Renewed with Premera, December 2002

Line of Business	Cancelled		New		Renewed	
	Number of Groups	Members	Number of Groups	Members	Number of Groups	Members
Eastern Washington						
Large Group						
Small Group						
Total						
Percent of Large Groups in E WA						
Western Washington						
Large Group						
Small Group						
Total						
Percent of Large Groups in W WA						
Statewide Total						
Large Group						
Small Group						
Total						
Percent of Large Groups Statewide						

PROPRIETARY MATERIAL REDACTED

Note: The Percent of Total Large Groups is equal to the number of groups divided by the sum of the cancelled, new, and renewed large groups.
Small Group is defined as 1-50 employees.
"na" indicates not available.

Source: Premera Business Decision Reports, December 2002.

competitive pricing, this amount of turnover in the accounts does not indicate a reluctance of companies to try a new health plan due to switching costs. Insurers constantly work to retain business and to find new business. Switching costs are not sufficiently high to allow any insurer to rest on its past market share successes. Switching costs do not create a barrier to entry or expansion, particularly if employers were to be faced with attempted monopoly pricing.

PROPRIETARY MATERIAL REDACTED There are many significant examples of switching by major employers. In one example alone, Premera lost a single large group of over [ ] members in Eastern Washington PROPRIETARY MATERIAL - REDACTED [ ][76] Premera also lost a [ ] member contract with [ ] in 2003, a [ ] member contract with [ ] in 2003, a [ ] member contract with [ ] in 2003, and a [ ] member contract with [ ] also in 2003.[77] On the "win" side, Premera recently took the Microsoft contract away from Aetna, adding 85,000 members in 2003.[78] It also won two [ ] member contracts in 2003 with [PROPRIETARY MATERIAL REDACTED] These examples reflect actual switching behavior. This is not what we would expect if there were "true" economic barriers to entry and expansion due to high switching costs.

c. Other Structural Characteristics

There are several other structural factors that economists generally consider when analyzing whether a firm has market power. The most important of these may be the presence of large, sophisticated buyers. In this matter, one category of large, sophisticated buyers is the employers who have the ability to self-insure if they think the premiums being charged by the insurers are too high. Through our interviews with Premera senior management, we have learned that most of the large employers in the state are already self-insured, and that there are many third party administrators ("TPAs") that compete with the existing insurers for this business. We have also learned that many mid-size employers have seriously investigated the option of self-insuring in an effort to lower health care costs. Some small groups have also come together in "associations" to either pool their insurance volume or to self-insure.[79] The fact that at least the large and mid-size employers can self-insure in response to excessive premiums is further

---

[76] Based on interview with Premera senior management.

[77] See Premera's "Performance Quarterly Reports to Board of Directors" for the first two quarters of 2003.

[78] *Ibid.*

[79] Groups of employers in Washington may band together specifically to purchase health care insurance. [RCW 48.44.024]

evidence that Premera does not have market power. At least for large groups, Dr. Leffler agrees that there is no competitive worry, in large part, due to their option to self-insure.[80]

Another important category of well-informed and sophisticated buyers is represented by the agents, brokers, and consultants who help companies and individuals purchase health insurance. These brokers know how to effectively play one insurer off another by seeking bids and directing volumes of members to those insurers that offer good premiums, broad networks and good service. Often these brokers work closely with human resources departments in large companies, who themselves are very well-informed about the best value for health insurance available to their employees. Brokers and consultants will put together extensive requests for proposals to be submitted by insurers, evaluate the responses and negotiate the contracts on behalf of medium and large companies. For other groups, brokers frequently "spreadsheet" the prices and product offerings of a variety of insurers reflecting the bids available to the group. Agents often work with small groups and individuals and inform them of options available in the market. Collectively, these agents, brokers, and consultants assure that the buying side of the market is very informed and price sensitive.

Finally, another important structural factor that constrains pricing by insurers like Premera is the fact that the small group and individual lines of business in Washington are subject to significant regulation. In particular, the insurance commissioner has the ability to deny the rates and contracts in the small group business if the commissioner deems them to be unreasonable. Moreover, even though the individual business rates are not regulated in the same way as those of the small group business, the insurers still have to file their rates and contracts with the state. If an insurer's annual individual medical loss ratio falls below 74 percent (minus applicable premium tax rate), the insurer must remit a percentage of its annual individual premiums to the state's high-risk pool. The percentage remitted is the difference between the 74 percent (minus the applicable premium tax rate) and the carrier's actual loss ratio. In addition, state law requires that both the small group and individual rates be determined based on statewide community rating, which makes it very unlikely that Premera could ever raise these rates above competitive levels since most of Premera's business is in Western Washington and most observers, including both Dr. Leffler and PwC, agree that the health insurance business in

[80] See Report of Dr. Leffler, p. 19 ("However, for large employers, the large pool of employees implies that self insurance can be an effective alternative to commercial insurance.")

Western Washington is very competitive.[81] All of the above represents further evidence that Premera does not have market power over buyers in Washington.

3. Direct Approach: Analysis of Competitive Effects

a. Price Comparisons

We have also analyzed whether Premera charges higher premiums than its competitors. To compare premium levels across insurers in Washington, we used multiple regression analysis to examine whether Premera's annual premiums per member are significantly greater than its competitors' annual premiums per member, holding constant differences in medical benefits, mix of membership, and inflation.[82] The basic model consists of regressing each health plan's premiums per member against an intercept, the medical expenses per member paid by the health plan, the HMO share of the health plan's total enrollment, the Medicare managed care share of the health plan's total enrollment, the Medicaid managed care share of the health plan's total enrollment, a Premera "dummy" variable (set to 1 if the observation represents Premera's health plan and 0 otherwise), and yearly "dummy" variables. If the estimated regression coefficient for the Premera dummy variable is positive and statistically significant, this would indicate that Premera charges significantly higher premiums than its competitors and, therefore, it might have market power. In such a case, further investigation would be warranted regarding, for example, the size of the premium difference and its sustainability.

The data used in this analysis consist of panel data that contain information about every health insurer that competed in Washington during the period 1997 through 2002. These data indicate the premiums, medical expenses, and enrollment for each insurer's fully-funded products.[83] We collected the data from the OIC filings (total premiums, total medical expenses,

---

81 *Ibid.*, p. 23 ("Indeed, in Western Washington, Regence is the largest insurer though neither Regence nor Premera is dominant based on typical economic measures. Therefore, on a priori grounds, there is no expectation that Premera has any ability to control premium levels or provider reimbursements in Western Washington.") and PwC's Economic Impact Report, p. ES-8 ("Premera dominates the insurance market in Eastern Washington, with some limited exceptions. Its Dimension product design may allow it to take greater opportunity of its market power in that area . . . Premera is one of several carriers operating in Western Washington and is restricted in its ability to increase premiums in those areas.")

82 Multiple regression analysis is a statistical technique that allows a researcher to determine the separate effect of each explanatory variable (e.g., medical expenses per member) on the dependant variable (i.e., premiums per member), holding constant the effects of the other explanatory variables (e.g., HMO share of total enrollment). For a more detailed description of this statistical technique, see, Daniel L. Rubinfield, "Econometrics in the Courtroom," *Columbia Law Review* 85 (1985), pp. 1048-1097.

83 As mentioned earlier, the information for the self-insured products is not publicly available.

and total enrollment for all years and HMO enrollment, Medicare managed care enrollment, Medicaid managed care enrollment, and Medicare supplement enrollment for 2000 through 2002), Interstudy (HMO enrollment for 1997 through 1999), and the federal government's Center for Medicare and Medicaid Services ("CMS") website (Medicare and Medicaid managed care enrollments for 1997 through 1999).[84] Since our regression model controls for only a subset of the factors that could influence each insurer's premium level, we have estimated a number of variations of the model to evaluate whether the results are robust.[85]

Table 9 summarizes the results of our regression analysis.[86] The results show that the explanatory variables collectively explain a very high percent of the variation in the premiums per member, i.e., about 98 percent as shown by the "R-squares," which equal 0.98. This indicates that the explanatory variables are very helpful in explaining the differences in premiums across health plans. The results also show that the most significant explanatory variable is the medical expenses per member.[87] This indicates that the plans that have the richest benefits charge the highest premiums. Finally, the results show that the Premera dummy variable is always insignificant, i.e., the estimated regression coefficient for this variable always has a t-value that is insignificant at the traditional 5 percent level of statistical certainty. This indicates that Premera's premiums are not materially higher or lower than the premiums charged by the other insurers in Washington, holding constant differences in medical benefits, mix of membership, and inflation. These results support the conclusion that Premera's premiums are in the mainstream of the premiums charged by the other Washington insurers and that Premera does not have market power.

---

[84] There were a few instances during the period 2000 through 2002 where the OIC filings did not report the HMO, Medicare managed care, or Medicaid managed care enrollments. In those instances, we used the figures reported by Interstudy and CMS.

[85] The variations deal primarily with how the data are aggregated, that is, whether the data are aggregated at the parent level or the plan level. The variations also include alternative explanatory variables to control for the mix of membership and inflation

[86] These results do not directly control for what share of each insurer's membership is made up of Medicare Supplement members. Since Premera has a sizeable number of Medicare Supplement members, this could be causing Premera's premiums per member to be lower than they otherwise would be. However, controlling for the Medicare Supplement factor does not change the results. [See Table B-2 in Appendix B.]

[87] That is, the estimated regression coefficient for this variable always has the highest t-value in absolute value terms.

Table 9: Summary of Results for Premium Regressions

Dependent Variable: Premiums per Member
Coefficients / (t-statistics)

	Parent Regressions		Plan Regressions	
Explanatory Variable	Year Dummies	Time Trend	Year Dummies	Time Trend
Constant	287.93 **	288.24 **	301.64 **	275.50 **
	(3.67)	(3.91)	(4.91)	(4.69)
Medical Expenses per Member	0.81 **	0.81 **	0.82 **	0.82 **
	(63.86)	(65.95)	(73.64)	(75.29)
HMO Membership Percent	-1.16	-1.19	-1.24	-1.23
	(-1.05)	(-1.10)	(-1.69)	(-1.70)
Medicare Managed Care Membership Percent	1.97	1.97	1.58	1.57
	(1.41)	(1.43)	(1.53)	(1.55)
Medicaid Managed Care Membership Percent	12.93 **	12.79 **	10.81 **	10.77 **
	(3.78)	(3.80)	(3.75)	(3.80)
Premera Dummy Variable	117.05	115.76	32.19	31.82
	(0.86)	(0.86)	(0.35)	(0.35)
R-Square	0.98	0.98	0.98	0.98
F-Statistic	482.73 **	825.73 **	614.85 **	1,053.56 **
Observations	98	98	140	140

* Significant at 5 percent level.
** Significant at 1 percent level.

b. Profit Comparisons

To compare profits in this matter, we have used the health plans' underwriting margins, which are defined as premiums minus medical expenses minus administrative expenses all divided by premiums.[88] In particular, we have used both "total underwriting margins" that cover all lines of business, as well as "line of business margins" that cover individual lines of business only.[89] The data that we have relied upon for this analysis come from the Washington State

[88] Economists generally consider profit comparisons to be less reliable than price comparisons, although profitability over time is, in theory, a superior measure of significant market power. The reluctance to use profits is because they are based on accounting practices that can differ substantially across firms. For example, accounting practices can differ in how (1) depreciation and bad debt are measured, (2) general administrative and overhead expenses are allocated, and (3) inventory and supplies are priced. Moreover, profits must be "extra-normal" over a sustained period before they can possibly be interpreted as an indicator of market power. Otherwise, a "spike" in profits (or in premiums) may simply be a temporary signal to the market that competitive expansion or new entry is warranted. Thus, profit indicators must be calculated and interpreted cautiously.

[89] Note that the study of total underwriting margins is generally more appropriate to analyzing whether market power exists in the relevant market that we have identified (i.e., all health insurance in the state of Washington), though some unrelated business activities are also reflected in this measure of margin (e.g., health insurance business outside the state and dental, vision or other specialty coverages). The "line of business" margins do not

Hospital Association (total margins) and from the OIC (line of business margins). The data cover the periods 1997 through 2002 for the total margins, and the year 2002 for the line of business margins.

Table 10 presents the results for the total underwriting margins. The results show that, between 1997 and 2002, Premera Blue Cross's total underwriting margin fluctuated quite a bit from a low of -3.3 percent in 1997 to a high of 3.0 percent in 2001 and then back down to 0.2 percent in 2002.[90] The results also show that, during this same period, there were a number of

Table 10: Underwriting Margins for Selected Washington Health Plans, 1997 – 2002

Plan Name	1997	1998	1999	2000	2001	2002
United Healthcare of Washington	na %	(37.6) %	(22.1) %	(11.1) %	(27.9) %	160.8 %
Molina Healthcare of WA	-	-	-	4.0	6.3	11.3
Providence Health Plan	(16.7)	(1.6)	(14.5)	6.3	(12.8)	4.7
Kaiser Foundation Health Plan	(3.8)	(2.9)	(1.8)	(0.2)	1.4	4.1
Regence BlueCross BlueShield of OR	0.2	4.9	(1.6)	6.1	3.0	3.0
Asuris Northwest Health	(25.6)	(22.0)	(9.1)	(6.2)	(6.1)	1.6
Community Health Plan of WA	0.9	(0.2)	1.8	2.5	3.7	1.5
Regence Health Maintenance of OR	(9.4)	(12.7)	(2.2)	1.1	6.9	0.7
Group Health Cooperative	(10.8)	(8.0)	0.4	(0.4)	0.4	0.6
Premera Blue Cross	**(3.3)**	**(1.7)**	**1.1**	**0.4**	**3.0**	**0.2**
Premera HealthPlus	(7.0)	(1.5)	0.3	-	-	-
Medical Service Corp of Eastern WA	(6.2)	-	-	-	-	-
Regence BlueShield	(1.1)	(4.2)	(2.9)	(1.2)	1.4	(0.1)
PacifiCare of Washington	(29.6)	(1.3)	0.4	2.3	1.1	(0.2)
Columbia United Providers	10.8	(0.8)	4.1	2.0	1.6	(0.5)
KPS Health Plans	(9.0)	(7.1)	(8.2)	(5.4)	0.4	(0.7)
Group Health Options	(3.5)	(1.7)	(2.6)	1.1	(1.3)	(1.1)
One Health Plan of Washington	-	(12.0)	(2.6)	12.3	(12.9)	(7.5)
RegenceCare	(17.8)	(14.9)	(13.4)	(15.8)	(3.3)	(7.5)
Premera LifeWise Health Plan	-	-	-	-	(29.1)	(12.1)
Aetna U.S. Healthcare of WA	-	(14.7)	(9.3)	12.5	4.8	(13.7)
First Choice Health Plan	(18.3)	(13.1)	(4.0)	(7.2)	(11.3)	(15.5)
Aetna U.S. Healthcare (HMO)	(15.7)	14.2	(1.8)	(0.6)	(12.3)	(16.2)

Notes: Figures reflect all fully-insured business in the state of Washington including dental and vision business.
Figures do not include disability insurers that offer health insurance.
"na" indicates that the health plan existed but information was not available for that year.
"-" indicates that the health plan was not available in that year.

Source: Washington State Hospital Association, "Profile of Washington State Health Plans," Fall 1998 to 2003 Reports.

match the relevant market as closely but are presented to examine whether there might be profitability issues across separate lines of business. Measuring profits across lines of business is particularly difficult since there are necessarily several subjective allocations of common costs assigned to each line of business that may not reflect the true costs of offering that line of business.

[90] The margin for 1997 represents the margin for Blue Cross of Washington and Alaska. Premera Blue Cross was not formed until 1998.

other health plans with higher total underwriting margins than Premera Blue Cross. For example, during its best year (i.e., 2001), there were four other health plans that had a higher margin than Premera Blue Cross and one other health plan that had the same margin. These results demonstrate that Premera's total underwriting margins have been in the mainstream of the margins experienced by the other health plans in Washington. Thus, they also support the conclusion that Premera does not have market power.

The results for the line of business underwriting margins are presented in Table 11. Although none of the individual lines of business by itself represents a separate relevant market, we have examined the underwriting margins for each of them since Dr. Leffler has argued that each line of business might represent a separate relevant market.[91] The available information shows that Premera's underwriting margins for each line of business in 2002 were in the mainstream, except for the Medicare managed care margins. For example, Table 11 shows Premera's underwriting margins for the large group, small group, and individual businesses in

Table 11: Underwriting Margins for Washington Health Plans, By Line of Business, As of December 31, 2002

Plan Name	Total	Individual	Small Group	Large Group	Basic Health Plan	Public Employees (PEBB)	Federal Employees (FEHB)	Medicaid Managed Care	Medicare Managed Care	Medicare Supplement
United HealthCare of WA	160.8 %	- %	- %	160.8 %	- %	- %	- %	- %	- %	- %
Molina Healthcare of WA	11.3	-	-	-	6.0	-	-	11.5	-	-
Providence Health Plan	4.7	-	(5.9)	13.1	-	-	-	-	-	-
Kaiser Foundation Health Plan	4.1	3.3	3.3	3.3	3.3	3.3	2.3	(25.9)	2.4	-
Regence BlueCross BlueShield of OR	3.0	19.6	9.3	(6.9)	-	-	-	-	-	20.1
Asuris Northwest Health	1.6	(11.3)	3.9	(0.4)	-	-	-	-	-	12.7
Community Health Plan of WA	1.5	-	-	-	(0.8)	(3.7)	-	3.8	-	-
Group Health Cooperative	0.6	(2.5)	1.7	(1.3)	(0.2)	4.0	4.5	(21.8)	4.1	-
Premera Blue Cross	**0.2**	**2.9**	**(0.2)**	**(0.4)**	**3.2**	**(15.5)**	**(0.5)**	**0.6**	**361.1**	**9.5**
Regence BlueShield	(0.1)	(4.4)	3.6	(4.2)	4.2	744.9	0.2	13.9	-	7.8
PacifiCare of WA	(0.2)	11.1	(3.4)	(12.4)	-	(6.9)	(10.7)	-	3.8	-
Columbia United Providers	(0.5)	-	-	-	3.3	-	-	(1.3)	-	-
KPS Health Plans	(0.7)	1.4	7.0	(4.8)	-	-	0.3	-	-	6.2
Regence Health Maintenance of OR	(0.7)	-	7.5	(4.7)	-	-	-	-	(7.7)	-
Group Health Options	(1.1)	-	(4.5)	(1.3)	-	4.8	-	-	na	-
One Health Plan of Washington	(7.5)	-	(12.6)	3.4	-	-	-	-	-	-
RegenceCare	(7.5)	-	(3.9)	(12.0)	-	(7.1)	-	-	na	-
Premera LifeWise Health Plan of WA	(12.1)	(12.1)	(6.1)	-	-	-	-	-	-	-
Aetna U.S. Healthcare of WA	(13.7)	-	(33.4)	(18.1)	3.1	-	-	(7.5)	-	-
First Choice Health Plan	(15.5)	-	-	(16.2)	-	-	-	-	-	8.9
Aetna U.S. Healthcare (HMO)	(16.2)	(16.5)	(21.5)	(36.9)	-	(7.1)	16.7	-	-	-

Notes: Figures reflect all fully-insured business in the state of Washington including dental and vision business.
Figures do not include disability insurers that offer health insurance.
"na" indicates that the health plan existed but information was not available for that year.
"-" indicates that the health plan did not offer a product in that market segment.

Sources: Private insurers' annual statements filed with the OIC for the year ending December 31, 2002.

91 See Report of Keith Leffler, Ph.D., pp. 18-19 ("I have reached the opinion that there are relevant economic markets for the sale of health care insurance to particular groups, including individuals, the employees and dependents of small employers, and the employees and dependents of large employers, in the state of Washington.")

2002 equaled –0.4 percent, -0.2 percent, and 2.9 percent, respectively. The table also shows that there were at least four insurers in the large group business, seven insurers in the small group business, and three insurers in the individual business that had higher margins. Finally, even though the table shows that Premera had a very high margin in the Medicare managed care business in 2002, this result reflects accounting distortions more than real profitability since Premera pulled out of the Medicare managed care business altogether at the end of 2001. Obviously, it would make little sense to pull out of a business if it were truly such a high-margin business. Thus, taken together, this information also supports the conclusion that Premera does not have market power.

4. Conclusion

All of the information set forth above demonstrates that Premera does not have market power and that the health insurance market in the state of Washington is competitive. In particular, the results of the market structure approach show that there are a number of structural factors (e.g., number and size of competitors, entry and expansion conditions, ability of employers to self-insure, and regulatory oversight) that force Premera to charge competitive premiums. In addition, the results of the indirect or competitive effects approach confirm this conclusion. Premera's premiums and underwriting margins have been in the mainstream of those of the other commercial insurers that compete in Washington.

The conclusion that the health insurance business in Washington is competitive is the same basic conclusion that Dr. Leffler has reached.[92] While Dr. Leffler suggests that Premera may have some market power in Eastern Washington, he acknowledges that regulatory and competitive constraints prevent Premera from exercising any such market power.[93] Even assuming that Eastern Washington represents a separate relevant market from Western Washington (which it is not based on our findings), the fact that Premera cannot increase premiums above competitive levels in Eastern Washington is evidence that Premera does not have

---

92 As mentioned earlier, most economists consider a market that is producing a competitive outcome to be competitive. In his report, Dr. Leffler states, "I did not find any evidence that Premera is taking substantial advantage of any market power it may have in setting premiums at this time." [Report of Keith Leffler, Ph.D., pp. 3-4] Thus, Dr. Leffler appears to have concluded that the market is producing a competitive outcome.

93 Report of Keith Leffler, Ph.D., p. 44 ("I have found evidence that Premera has some market power both in selling insurance and in purchasing providers' services. However, any such market power is limited to Eastern Washington. . . However, the exercise of Premera's market power is constrained by the OIC rate setting rules concerning variation in premiums by area and also by competitive alternatives to Washington registered insurers available to large groups.")

market power in Eastern Washington. The factors that Dr. Leffler is pointing to as the reason why Premera is not exercising market power in Eastern Washington are the same factors that we would point to as the reason why Premera does not have market power in Eastern Washington. By definition, market power is the ability of a firm to profitably increase prices above competitive levels for a sustained period of time, and clearly Premera does not have this ability in Eastern Washington or anywhere else in the state.

B. The Proposed Conversion Will Not Change the Current Market Conditions in the Health Insurance Market

Given our finding that Premera does not have market power in the health insurance market, the only way that the proposed conversion could substantially lessen competition in that market is if it somehow enabled Premera to monopolize that market. For this to take place, Premera would have to substantially change the structural conditions in the market that now assure a competitive outcome. At a minimum, Premera would have to drive its existing competitors out of business, perhaps by charging extremely low premiums for a long enough time to force them to exit. Of course, Premera would also have to prevent former rivals from entering or re-entering the market as it tried to recoup its predatory pricing losses by increasing its premiums above competitive levels. This is simply implausible.

First, in addition to a wide range of rivals, Premera currently faces two large competitors (i.e., The Regence Group and Group Health), each of which has roughly the same share of the market as Premera. In addition, both of these large rivals offer most of the same products and compete in most of the same lines of business as Premera. This means that it is extremely unlikely that Premera could drive these two competitors out of business since it would have to engage in a sustained and deep pricing war over many products over a wide geography to win large enough business from these two well-established rivals to drive them out of the market. Second, Premera also faces a number of other competitors that include many of the largest insurers in the country (e.g., Aetna, CIGNA, Health Net, Kaiser, and PacifiCare). Given that these insurers are much bigger than Premera, it is extremely unlikely that Premera could drive them out of business or keep them out once Premera tried to raise premiums to supracompetitive levels to recoup its predatory investments. Finally, even if Premera could drive its existing competitors out of business, it would have to be able to prevent new competitors from entering the market. Given that there are no apparent barriers to entry, it is illogical to assume that Premera could accomplish such a hypothetical monopolization attempt.

One might argue that as a result of the conversion Premera will be forced to charge higher premiums to meet the profitability expectations of its stockholders. However, this argument ignores the reality of current and future market conditions. Premera faces a number of competitors in each of the lines of business that it competes in and many of these competitors offer most (if not all) of the same products that Premera offers. [See again Tables 1 and 2.] It also ignores the fact that Premera's premiums and profits are currently in the mainstream of its rivals and that they will remain that way as a result of the agents, brokers, and consultants regularly comparing all of the insurers' product offerings to ensure that the insurers continue to compete vigorously for their clients' business. If Premera tried to raise its premiums above competitive levels, it would quickly lose a substantial amount of business to its competitors. Thus, even if the conversion were to create added pressure on Premera to increase its profitability, Premera would not be able to do so by increasing its premiums. In fact, Premera has tried to improve profitability by its efforts to control SGA costs rather than by increasing premiums relative to its rivals. The same market conditions will hold after the conversion.

Based on the above analysis, we conclude that the proposed conversion is not going to change the current market conditions in the health insurance market. The market will remain competitive. Dr. Leffler has reached the same basic conclusion.[94] However, in contrast to both our findings and Dr. Leffler's, the OIC's economic impact consultant, PwC, has reached the opposite conclusion. In its report, PwC appears to argue that the conversion together with the implementation of the Dimensions products will somehow enable Premera to increase its premiums above competitive levels to the large groups, small groups, and individuals in Eastern Washington.[95] PwC gives no explanation to how this will occur and ignores the economic realities of the marketplace that we have described above.

---

94 *Ibid.*, p. 4 ("The analysis performed in this report is not intended to provide an answer to the question of whether the conversion of Premera to for-profit status may result in higher insurance prices . . . Nonetheless, if Premera continues to compete statewide and if the OIC assures that the variance in individual and small group premiums result only from regional cost differences, then there is little reason to expect any change in the pricing of these policies . . . For the large groups, Premera can elect to deviate from its traditional premium setting procedures . . . However, any market power with respect to large groups is constrained by the possibility of self insurance and entry.")

95 See PwC's Economic Impact Analysis, p. ES-6 ("Premera's revenue growth goals will require increases in premiums and enrollment. Additionally, high performing stock companies consistently meet net operating margin goals in all lines of business . . . To reach net operating margin targets Premera will need to either attain greater savings in health care costs or administrative expense or to increase premiums.), p. ES-8 ("Premera dominates the insurance market in Eastern Washington, with some limited exceptions. Its Dimension product design may allow it to take greater opportunity of its market power in that area."), and p. 95, Table 9-2 (which shows that there will be sizeable premium increases to the individual, regulated small group, small group, and large group lines of business).

IV. The Proposed Conversion Will Not Reduce Reimbursement Rates

A. Premera Does Not Have Market Power on the Buying Side of the Provider Markets

Market power on the buying side of a market is generally defined as the ability of a firm to profitably lower reimbursement rates *and* the quantity of input use below long-run competitive levels for a sustained period of time.[96] As with examining market power on the selling side, economists generally use both a "market structure" approach and a "competitive effects" approach to determine if a firm has market power on the buying side of a market.

The "market structure" approach involves identifying the relevant market, determining the firm's share of the total purchases in that market, evaluating entry and expansion conditions for other buyers, and investigating other structural factors (such as the presence of negotiated contracts, the ability of the sellers to easily exit the market, or countervailing market power on the sellers' side of the negotiations) that could prevent the firm from reducing reimbursement rates and the quantity of input use. If the firm has a very large share of the total purchases, if entry or expansion by other buyers is difficult, if most contracts are "take-it-or-leave-it" contracts (absent efficiency justifications), if the entry or exit of sellers is difficult, *and* if the sellers do not have any countervailing market power, these factors may indicate that the firm has the ability to exercise market power (though again these indicia are not dispositive given the inferential nature of this approach).

The "competitive effects" approach generally involves comparing the reimbursement rates of the firm in question with the reimbursement rates of comparable firms that operate under competitive conditions. However, in the situation where there are standard rates in the market (such as the amounts reimbursed by the federal government's Medicare program, i.e., the fees paid to physicians under the Medicare RBRVS system), the approach can also involve comparing the reimbursement rates of the firm in question to these benchmark, standard rates. If the firm in question has reimbursement rates that are significantly and consistently lower than either the

[96] Many economists refer to this type of market power as monopsony power. See, e.g., M. Pauly, "Managed Care, Market Power, and Monopsony," *Health Services Research* 33 (December 1998), pp. 1439-1460; also T. McCarthy and S. Thomas, "Antitrust Issues Between Payers and Providers," prepared for the ABA-AHLA Health Care Antitrust Meetings, Washington DC, May 17-18, 2001. (Reprinted in two parts in *Antitrust Health Care Chronicle*, Chicago: American Bar Association, Spring 2002 and Summer 2002.)

reimbursement rates of the comparable firms or the standard rates that are in the market, this may indicate that the firm has market power on the buying side of the market. Further analysis would be warranted.[97]

We use both the indirect and direct approaches to evaluate whether Premera has market power on the buying side of the provider markets in the state of Washington. We conclude that Premera does not have market power in any provider market and that therefore these markets are competitive.

1. The Relevant Markets

In analyzing whether the proposed conversion is likely to reduce reimbursement rates to providers below competitive levels, it is necessary to identify the *relevant market* in which the providers compete. This delineation of the *relevant market* will indicate all of the alternative sources of patients and payers that the providers could turn to for contracts and reimbursement if Premera tried to lower reimbursement rates below competitive levels. If there are enough alternative sources of patients and payers, then Premera would be unsuccessful in any attempt to lower reimbursement rates since the providers would be able to avoid dealing with Premera by turning to these alternative sources for their patients.[98]

As mentioned above, a *relevant market* contains both product and geographic dimensions. However, the product dimension of the relevant market does not appear to be an important issue in this matter since the apparent concern is that the conversion might allow Premera to lower reimbursement rates to all providers, regardless of type. Therefore, instead of focusing on the nuances of the *relevant product market* question, we instead focus our attention on the *relevant geographic market* question. This is the same approach that Dr. Leffler takes in his report.

The *relevant geographic market* for provider services is generally considered to be more local than the relevant geographic market for health insurance because insurers can usually enter

---

97 The "competitive effects" approach also involves comparing the quantity of input use of the firm in question. However, this step is usually performed only if the researcher finds some indication that reimbursement rates have been lowered below competitive levels. This is because the comparison of the quantity of input use is often much more difficult than the comparison of reimbursement rates and because a reduction in reimbursement rates below competitive levels is a necessary condition for a firm to have market power on the buying side. Finally, in health care markets, the quantity issue is confused by the fact that some activities of insurers are specifically designed to reduce care that is unnecessary or inappropriate. Thus, not all reductions in the quantity of input use are necessarily bad if "too much" care was being produced to start with.

98 Even if there are not currently enough alternative sources of patients, any attempt to lower reimbursement rates below competitive levels could result in other health insurers entering the market to take advantage of relatively lower provider rates, which would then be bid up in the process of new entry or expansion.

and expand into geographic areas much easier than most providers can.[99] Based on our prior experiences in litigation and merger reviews, we have always found the relevant geographic markets for physician and hospital services to be larger than single counties and usually to be at least as large as metropolitan statistical areas ("MSAs"), which are often made up of multiple counties. Likewise, in all of the hospital merger cases that have been litigated, the courts have always found that the relevant geographic markets for hospital services to cover multiple counties and usually to be at least as large as MSAs.[100] In addition, in the Aetna-Prudential health plan merger, the U.S. Department of Justice (DOJ) concluded that for purposes of analyzing the physician reimbursement issue in that case the relevant geographic markets for physician services equaled MSAs, which were broadly defined. For example, the Dallas-Ft. Worth provider market was made up of fourteen counties, according to the DOJ. Finally, although there is no consensus in the literature about how large the relevant geographic market for physician services should be, some recent studies consider the relevant geographic market for physician services to be at least as large as health service areas ("HSAs")[101] or metropolitan statistical areas ("MSAs").[102]

To identify the *relevant geographic market* in physician or hospital cases, economists sometimes rely on standard geographic market tests that require detailed patient origin data indicating the patient residences, the location of the providers that they used, and the treatments that they received. Unfortunately, as in many cases, such detailed data are not available in this matter. Therefore, we assume that the relevant geographic markets for provider services are at least as large as HSAs and MSAs and possibly even as large as a region, in this case, Western Washington and Eastern Washington, each of which is analyzed separately. Although these geographic areas are much larger than the single counties being used by Dr. Leffler and PwC, we

---

99 For physicians, mobility and responsiveness to market opportunities in other areas can vary greatly by specialty. For example, anesthesiologists can readily move to other areas and fit in immediately. More generally, we are unaware of any studies that test the relevant geographic market for physicians by looking at which specialties move most readily in response to earnings differences. The assumption used here, that provider markets are more local than insurer markets, should be regarded as a conservative approach to looking at provider markets since it assumes very little mobility in response to earnings differentials, yet we see considerable entry and exit of physicians over time.

100 See, e.g., T. McCarthy and S. Thomas, "Geographic Market Issues in Hospital Mergers," in Douglas C. Ross and Mark J. Horoschak, *Health Care Mergers and Acquisitions Handbook,* Chicago: American Bar Association, 2003.

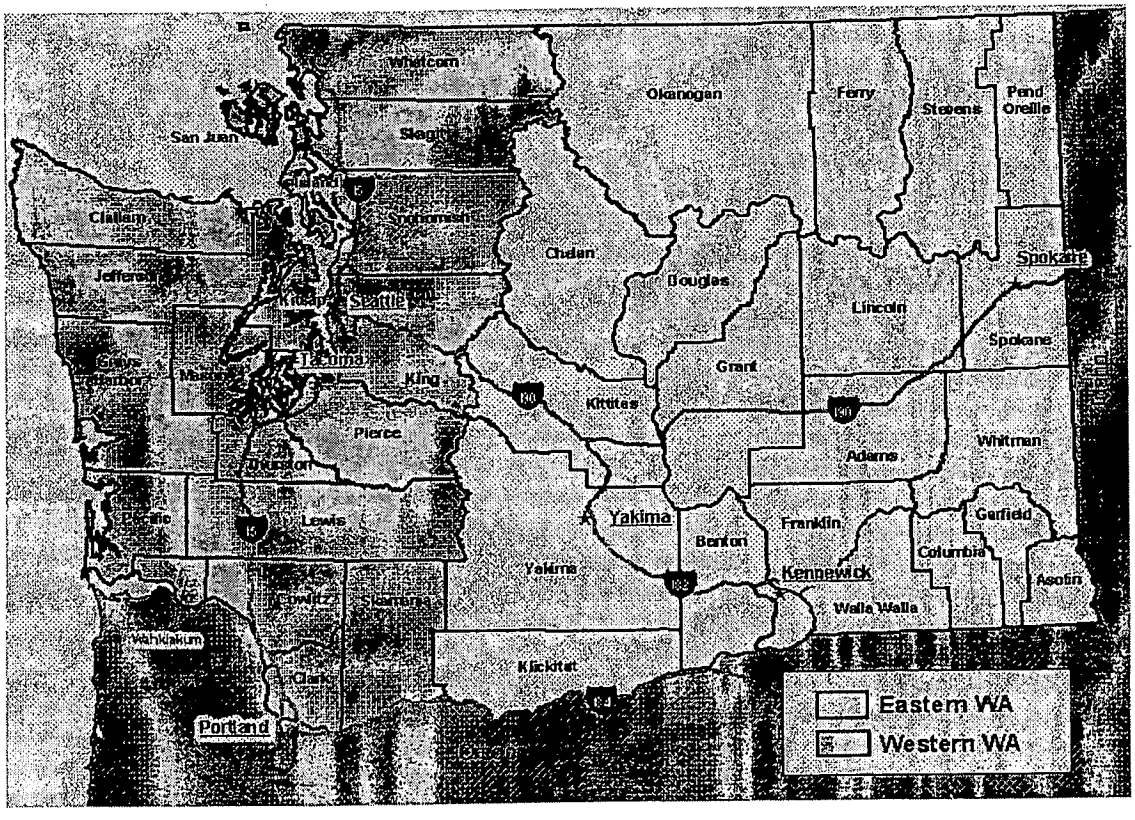
101 HSAs represent geographic areas that have been identified using hospital patient flow information for Medicare patients. See, e.g., National Center for Health Statistics, CDC, "Vital and Health Statistics, Health Service Areas for the United States, Series 2: Data Evaluation and Methods Research, No. 112," November 1991.

102 See, e.g., R. Feldman and D. Wholey, "Do HMOs Have Monopsony Power," *International Journal of Health Care Finance and Economics* I (2001); also J. Hadley and J. Mitchell, "HMO Penetration and Physicians' Earnings," *Medical Care* Vol. 37 (1999), pp. 1116-1127.

believe, for the reasons noted above, that they provide much better approximations of the "true" relevant geographic markets for providers. However, as will be explained in more detail below, this difference in the size of the geographic areas does not affect our conclusion regarding whether any of the provider markets in Washington are competitive.

It is our understanding that most observers, including Dr. Leffler,[103] consider the buying side of the provider markets in Western Washington to be very competitive. This means that Premera's actual performance in Western Washington can provide a benchmark by which to evaluate whether Premera has market power in Eastern Washington. Thus, the following discussion deals primarily with market conditions in Eastern Washington. Figure 1 is a map of the twenty counties that we consider to comprise Eastern Washington for the purposes of our analysis. These are the same counties used by Dr. Leffler.[104]

Figure 1: Map of Eastern Washington Counties



[103] See Report of Keith Leffler, Ph.D., p. 23 ("Indeed, in Western Washington, Regence is the largest insurer though neither Regence nor Premera is dominant based on typical economic measures. Therefore, on a priori grounds, there is no expectation that Premera has any ability to control premium levels or provider reimbursements in Western Washington.")

[104] *Ibid.*, Table 1.

2. Indirect Approach: Analysis of Market Structure

a. Market Concentration

Table 12 provides an estimate of Premera's share of the total purchases of provider services in Eastern Washington in both 2001 and 2002.[105] These estimates are based on Premera's share of the total insured population in Eastern Washington, using data from various publicly available sources as well as revised 2002 Form B data from Premera.[106] These data provide a rough measure of how big Premera's influence on provider reimbursements is likely to be. The table shows that Premera's estimated share of the total purchases of provider services in Eastern Washington equaled only 24.8 percent as of December 2001 and only 24.9 percent as of

Table 12: Premera's Estimated Share of the Total Purchases of Provider Services in Eastern Washington, 2001 – 2002

		2001	2002
(1)	Total Population	1,320,457	1,336,844
(2)	Uninsured Population	173,686	189,355
(3)	Covered by Military	61,458	67,054
(4)	Insured Population	1,085,313	1,080,435
(5)	Premera's Enrollment	268,624	269,131
(6)	Premera's Estimated Share	24.8%	24.9%

Notes: Premera's enrollment figures exclude Medicare Supplement and self-insured members.
Line (4) = Line (1) - Line (2) - Line (3)
Line (6) = Line (5) / Line (4)

Sources: Line (1): U.S. Census Bureau, "Washington County Population Estimates: April 1, 2000 to July 1, 2002."
Lines (2) & (3): U.S. Census Bureau, "Table HI-4, Health Insurance Coverage Status and Type of Coverage by State, All People: 1987 to 2002."
Line (5): 2001 and revised 2002 Premera Form B filings.

[105] Premera's estimated share of the total purchases of provider services in Western Washington is found in Table B-3 in Appendix B.

[106] The Form B data used to identify Premera's enrollment for 2002 has been revised from the data originally submitted to the state. During our analysis, we noted that enrollment data for some counties appear to be inaccurate. (Dr. Leffler noted similar inaccuracies in footnote 69 of his report.) Upon review with Premera, we have determined that coding and clerical errors were made on the data in the original filing. The Premera Form B data that we use in our report is the preliminary revision to the data that Premera will refile once Premera has reconfirmed the accuracy of these revisions. It can be found in Table B-4 in Appendix B.

December 2002. Given that the information indicates that Premera is currently responsible for less than one-fourth of all of the purchases of provider services in Eastern Washington, these estimates support the conclusion that there are plenty of other sources that the providers can turn to for patients and reimbursement if Premera tries to set monopsony reimbursement rates. Even by this rough indicator, it is clear that Premera does not have market power on the buying side of the provider services market in Eastern Washington.[107]

Other information also indicates that providers in Eastern Washington have plenty of other sources that they could turn to for patients and reimbursements. For example, through interviews with Premera's Health Care Delivery Systems management, we learned that there have been a number of situations where physicians have terminated their contracts with Premera when they felt they were not getting paid enough. One such situation occurred in 1999 when thirty-three physicians in Eastern Washington terminated or threatened to terminate their contracts after Premera published its fee schedule for that year. Another occurred in 2000 when thirty-two orthopedic surgeons in Spokane refused to contract with Premera. Eventually, all of these physicians came back to Premera as a result of Premera offering higher rates. Recently the plastic surgeons in Spokane terminated their contracts and the surgical specialists in Yakima refused to enter into a contract with Premera. Clearly, all of these Eastern Washington physicians felt that they could do without Premera or felt Premera could not do without them. [

PROPRIETARY MATERIAL REDACTED

] All of this evidence is clearly inconsistent with any concern that Premera might have buying-side market power in Eastern Washington.

b. Entry and Expansion Conditions

Putting aside Medicare and Medicaid, the other key buyers of physician services in this case are the commercial insurers. If commercial insurers are relatively free to enter and expand into a market, then the insurers currently operating in that area cannot underpay providers for fear of any new entrant offering better reimbursements and losing the provider partially or altogether. This means that the criteria for assessing entry and expansion conditions for the buyers are basically the same as the criteria discussed above when looking at entry and expansion conditions

[107] It could be argued that this evidence is misleading since Eastern Washington really consists of several different relevant geographic markets. However, separate calculations for the Eastern Washington HSAs, MSAs, and counties provide similar results. [See Tables B-5, B-6, and B-7 in Appendix B.]

for insurers on the selling side of the insurance market. The only difference is that entry in the case of the buyers can consist of either the commercial insurers entering the state as a whole (such as Health Net entering the Spokane area at the end of 2002) or the commercial insurers expanding their operations from one part of the state (e.g., Western Washington) to another (e.g., Eastern Washington).[108] Likewise, expansion in the case of the buyers consists of existing insurers in specific geographic areas (say, the Spokane area) enlarging their membership in the immediate area or by moving into contiguous counties.

As discussed earlier, there do not appear to be any significant barriers for (1) new insurers to enter the state, (2) existing insurers to expand their operations from one part of the state to another, or (3) existing insurers to enlarge their operations in any specific geographic location. Neither the regulatory requirements nor operational requirements for any of these actions are difficult to overcome when given the promise of a market opportunity. Moreover, the available information shows that there have been a number of recent examples of insurers actually expanding their operations from one part of the state to another. For example, during the last several years, at least four insurers who already had existing operations in Western Washington (such as NYLCare in 1997 and Providence in 2000) expanded their operations into other parts of Western Washington. [See again Table 3.] Likewise, at least four insurers who only had existing operations in Western Washington (such as the predecessor to Regence in 1995 and First Choice in 1998) expanded their operations into Eastern Washington. Finally, at least two insurers who already had existing operations in Eastern Washington (such as Regence in 1998 and Group Health in 2000 and 2001) expanded their operations into other parts of Eastern Washington. This information indicates that insurers can readily expand from one part of the state to another if they believe that they can earn greater profits by doing so. Thus, this information further supports the conclusion that Premera does not have market power on the buying side of the relevant physician markets.

In addition to there being recent evidence of insurers expanding from one part of the state to another, there is also recent evidence of insurers being able to enlarge their existing operations in Eastern Washington. For instance, Table 13 shows that, between 2001 and 2002, Community Health was able to increase its Medicaid enrollment in Eastern Washington by over 18,000. The table also shows that, during this same period, Asuris was able to increase its small group

[108] Entry in the case of the health insurance market represented entry into the state as a whole only. In particular, it did not include expansion from one part of the state to another since the relevant geographic market for the health insurance business consisted of the state as a whole.

enrollment in Eastern Washington by more than 10,000 members. Similarly, both CIGNA and Group Health grew their large group enrollments by more than 5,000 members between 2001 and 2002. The fact these insurers were able to enlarge their operations in Eastern Washington further supports the conclusion that Premera does not have buying-side market power.

Table 13: Examples of Enrollment Increases in Eastern Washington, 2001 – 2002

Plan	Line of Business	20-County Definition [1]			14-County Definition [2]		
		2001	2002	Increase	2001	2002	Increase
Asuris Northwest	Small	3,371	13,874	10,503	3,102	13,442	10,340
CIGNA	Large	7,661	14,155	6,494	7,409	10,367	2,958
Community Health	Medicaid	40,359	58,996	18,637	26,597	37,358	10,761
Group Health Options	Large	16,320	21,506	5,186	13,313	16,627	3,314
Molina	Basic Health Plan	1,705	5,534	3,829	1,705	5,534	3,829
Regence BlueShield	Large	20,464	21,026	562	3,821	6,647	2,826
Regence BlueShield	Small	4,256	8,163	3,907	379	934	555
Regence BlueShield	Individual	1,998	2,569	571	97	157	60

Notes: [1] Eastern Washington is defined as the 20 counties in Eastern Washington used by NERA and Dr. Leffler.

[2] Eastern Washington is defined as the 14 counties in Eastern Washington where Premera has the Blue Cross Blue Shield marks.

Source: 2001 and 2002 Form B filings.

PROPRIETARY MATERIAL REDACTED

Moreover, all of these insurers (except for Community Health) appear to have increased their membership at the expense of Premera. Table 14 shows that, between 2001 and 2002, Premera lost nearly [ ] members in Eastern Washington – nearly [ ] in its fully-funded large groups and more than [ ] in its fully-funded small groups. The ebb and flow of competition further supports the conclusion that Premera does not have market power on the buying side of the relevant provider markets. Premera is constantly challenging and being challenged by its rivals.

PROPRIETARY MATERIAL REDACTED

Table 14: Premera's Total Enrollment, Eastern and Western Washington, 2001 – 2002

Line of Business	December 2001 E WA	December 2001 W WA	December 2001 Total	December 2002 E WA	December 2002 W WA	December 2002 Total	Difference E WA	Difference W WA	Difference Total
Basic Health Plan	[								
Federal Employees (FEHB)									
Healthy Options									
Individual									
Large Group[1]				PROPRIETARY MATERIAL REDACTED					
Medicare Supplement									
Small Group[2]									
Fully-Insured									
Self-Insured									
Other									
Total Members			]						

Note: Eastern Washington is defined as the 14 counties where Premera has the Blue Cross and Blue Shield marks.

[1] Large Group includes 51-99 employees, 100+ employees, Associations, HealthPlus, PEBB and WEA.

[2] Small Group is defined as 1-50 employees.

Source: Premera Data.

c. Other Structural Characteristics

Three other structural characteristics that are instructive in assessing market power on the buying side of the market are the presence of negotiated contracts, the ability of sellers to quickly exit markets, and countervailing market power by the sellers. In general, negotiated contracts indicate that providers do not simply accept the reimbursements offered by an insurer. Also, in the case of physicians, such negotiations generally reflect a variety of organizational responses that physicians have given over the years to contract more effectively with managed care payers. These include provider consolidations into bigger single-specialty practices, the formation of multi-specialty groups or clinics, or the formation of independent practice associations ("IPAs") to contract on behalf of many physicians. All of these larger organizations generally have more bargaining strength with payers. Similarly, it can frequently be the case that small provider offices are in a position to command negotiated or customized fee schedules if they are in relatively small cities or rural areas with limited physician supply.

In the matter at hand, there is evidence that a large amount of Premera's physician payments are based on negotiated contracts. For example, Table 15 shows that, during the September 2002 through June 2003 period, approximately [ ] of Premera's payments to

PROPRIETARY MATERIAL REDACTED

physicians across the state were based on negotiated contracts.[109] During this same period, the percentage of physician payments based on negotiated contracts was actually greater in the urban and rural areas of Eastern Washington than in the urban and rural areas of Western Washington, respectively. (King County is the exception.) This further supports the conclusion that Premera does not have market power on the buying side of the markets for physician services in Eastern Washington.[110]

Table 15: Percentage of Premera's Medical Claims Paid by Negotiated Contracts, September 2002 - June 2003

		Allowed Claims			Percentage of Total Claims	
	Region	Standard Contracts	Negotiated Contracts	Total	Standard Contracts	Negotiated Contracts
	(1)	(2)	(3)	(4)	(5) (2) / (4)	(6) (3) / (4)
1	King County	PROPRIETARY MATERIAL REDACTED				
2	Western WA Rural					
3	Eastern WA Urban					
4	Eastern WA Rural					
5	Western WA Urban					
	Total					

Notes: Data based on claims incurred between September 2002 to June 2003 for Premera's standard and non-standard fee schedules. NERA included only those claims involving physicians. The following specialties were excluded from the analysis: administrative medicine, alcohol treatment, alternative medicine, audiology, blood bank, chiropractic, dentist, home health, hospice, manipulative therapy, mental health/social work, nutrician/dietician, occupational medicine, optical, oral surgery, other, physical therapy, physical-rehab-occupational, preventive medicine, public health, and speech therapy.

Source: Premera document titled "Premera Professional Provider Reimbursement, Claims Incurred 9/2002 - 6/2003, Paid Through 6/2003, By State, By County, By Specialty" for Standard and Non-Standard Fee Schedules, received August 14, 2003.

[109] It should be noted that the percentages in this table are somewhat larger than the percentages in the February 11, 2002 letter sent to Christine Gregoire, Esq., the Washington State Attorney General. One of the reasons for this is that the claims information in our table was pulled from a much more recent period than the claims information in the letter. In addition, the claims information in our table reflects payments to physicians only, whereas the claims information in the letter also reflected payments to other providers.

[110] The presence of negotiated contracts is also important because it indicates that the overall quantity of input use may not have been reduced. As mentioned earlier, for a firm to have market power on the buying side of the market, the firm must have the ability to lower both reimbursement rates *and* reduce the quantity of input use. In general, when evaluating whether a firm has market power, economists are primarily concerned with whether the actions of the firm will make society worse off by causing a misallocation of resources, as reflected by less health care being produced when fewer physician services are "hired." Even if a firm has the ability to lower reimbursement rates below competitive levels, most economists would not consider that to represent the kind of buyer-side market power that could harm economic efficiency unless the quantity of input use was lowered as well. [See, e.g., M. Pauly, "Managed Care, Market Power, and Monopsony," *Health Services Research* 33 (December 1998), pp. 1439-1460; also R. Feldman and D. Wholey, "Do HMOs Have Monopsony Power," *International Journal of Health Care Finance and Economics* I (2001).] Simply put, without a reduction in physician services, consumers benefit from lower input prices which competition in the health insurance market then forces to be passed on to consumers and employers in the form of lower premiums.

The available information about the number of physicians in this case indicates that there has been a sizeable amount of movement by physicians in Eastern Washington during the last ten years. Table 16 presents this information.[111] It was compiled using the American Medical Association's physician count data. The table shows that, during the period 1994 through 2002, the number of physicians practicing in Eastern Washington has steadily increased from 2,027 in 1994 to 2,549 in 2002. The table also shows that, even though the largest net increase has occurred in Spokane County, there have been net increases in most of the other Eastern Washington counties as well. Of the 20 counties located in Eastern Washington, 17 experienced net increases, 2 experienced net decreases, and 1 remained unchanged. Finally, the table shows that, even though over the whole period there were net increases in most of the counties, the

Table 16: Number of Physicians by County in Eastern Washington, 1994 – 2002

County	1994	1995	1996	1997	1998	1999	2000	2001	2002
Adams	13	14	15	10	12	13	12	12	13
Asotin	23	21	21	25	24	24	29	32	34
Benton	182	187	206	229	234	234	242	257	260
Chelan	154	162	180	190	192	196	192	196	200
Columbia	3	3	3	3	3	3	4	3	4
Douglas	10	7	8	7	9	8	17	18	15
Ferry	5	4	5	5	4	4	4	3	3
Franklin	36	42	47	44	46	47	45	44	51
Garfield	1	1	1	2	1	1	2	2	2
Grant	55	57	57	62	62	61	66	78	76
Kittitas	34	33	33	33	33	36	34	32	33
Klickitat	13	11	13	13	14	14	18	18	18
Lincoln	7	6	9	9	9	9	9	9	9
Okanogan	39	43	45	49	47	45	48	52	53
Pend Oreille	4	6	5	6	6	6	6	7	7
Spokane	935	946	967	990	1,011	1,010	1,029	1,069	1,127
Stevens	36	36	37	38	38	38	40	45	43
Walla Walla	118	116	126	131	134	129	141	147	158
Whitman	42	42	45	48	48	46	48	53	53
Yakima	317	317	334	360	356	366	360	378	390
Total	**2,027**	**2,054**	**2,157**	**2,254**	**2,283**	**2,290**	**2,346**	**2,455**	**2,549**

Note: Includes all specialties.

Source: AMA Physician Count, 1994 - 2002.

[111] The results in this table are for all physician specialties combined. The results for PCPs and specialists separately are basically the same. [See Table B-8 in Appendix B.]

number of physicians practicing in the smaller counties fluctuated quite a bit, with those counties experiencing actual decreases in many of the years. The fact that there has been a sizeable amount of movement by the physicians in Eastern Washington indicates that those physicians could readily exit Eastern Washington if they believed that they were not getting paid enough by Premera. Also, the fact that the number of physicians practicing in Eastern Washington has steadily grown over the last eight years is inconsistent with the notion that the physicians have been significantly underpaid in Eastern Washington. If they were underpaid, one would have expected to see a net decrease in the number of physicians and not a net increase like what we have actually observed. All of this further supports the conclusion that Premera does not have market power on the buying side of the provider services markets.

Finally, although we have not done a formal analysis to determine whether any of the providers in Eastern Washington have market power, it is likely that the very providers who depend most heavily on Premera for patients are also the same providers who have the most negotiating strength in dealing with Premera. Premera has a strong presence in some of the rural counties in Eastern Washington, but those are the very counties in which there are relatively few providers that Premera and other insurers can contract with to build a network and where compliance with the network adequacy requirement is most difficult. Thus, providers in those counties likely have more negotiating strength than the providers in the urban counties in Eastern Washington and, as such, likely can prevent Premera from lowering reimbursement rates below competitive levels.

3. Direct Approach: Analysis of Competitive Effects

a. Reimbursement Rate Comparisons

To examine whether Premera has market power on the buying side of the provider markets in Eastern Washington, we have used two different methods to look at the direct effects of Premera's actions in the input markets for provider services in Eastern Washington. Both methods rely upon examining physician reimbursement data. The first method involves comparing Premera's physician reimbursements in Eastern Washington to its physician reimbursements in Western Washington, measured as a percentage of Medicare RBRVS payments.[112] The Medicare RBRVS payment methodology is the approach that Medicare and

[112] RBRVS stands for resource based relative value scale. It is a fee-schedule system developed and used by the federal government in its Medicare program for reimbursing physicians. Many commercial insurers have based

many insurers use to reimburse physicians. It is based on Medicare assigning a specified number of units (i.e., relative values units or "RVUs") to each procedure or service according to the expected relative cost to a physician in providing that procedure or service. Medicare then multiples the number of RVUs by a constant dollar amount for each unit (i.e., a conversion factor) and by a geographic practice cost index ("GPCI") to determine the value of a given procedure or service. This reimbursement methodology provides a good benchmark for comparing reimbursement amounts since Medicare uses the same number of RVUs and the same conversion factor (but not the same GPCI) for all parts of the U.S. and virtually all physicians. That is, assuming that the mix of procedures and services are approximately the same in the geographic areas under analysis,[113] then this methodology allows one to directly compare the reimbursements paid by Premera (or any other insurer) in those geographic areas by restating them as a percentage of Medicare RBRVS payments.

The second method involves comparing Premera's physician reimbursements in Eastern Washington to its physician reimbursements in Western Washington, measured as allowed amounts per claim.[114] This method is similar to the one that Dr. Leffler used in Table 4 of his report except that it (1) includes an explanatory variable to control for the difference in intensity of services across claims, (2) uses allowed amounts instead of paid amounts, (3) examines many more physician specialties other than just PCPs and OB-GYNs, and (4) compares the difference in physician reimbursements directly by examining levels instead of indirectly by examining shares. As explained in greater detail below, the first two differences represent the biggest departure from Dr. Leffler's methodology since he did not address the data required to correct for these problems.[115] Also, we believe that the last difference is very important, since Dr. Leffler's

---

their fee schedules on the RBRVS system and many physicians use the Medicare fee schedule as a benchmark to evaluate how good or bad a commercial contract is (before signing up) by estimating the percentage of RBRVS that the contract is likely to pay them.

[113] This should not be much of a problem in the larger geographic areas. However, it could be a problem in the smaller geographic areas if the mix of procedures and services are not representative of all of the reimbursement rates that Premera has entered into in those areas.

[114] In reality, these two methods are very similar since they both use RVUs to control for the difference in intensity of services across claims.

[115] The use of allowed amounts instead of paid amounts allows one to control for the difference in copayments and deductibles associated with the different claims and the different underlying product designs. It is our understanding from discussions with management at Premera that copayments and deductibles can vary from area to area even for the same line of business based on differences in product designs chosen by employers and consumers.

statistical results are mainly inferential and they do not directly test whether Premera's physician reimbursement levels differ in Eastern and Western Washington.

(1) Medicare RBRVS Percentages

Figure 2 presents the Medicare RBRVS percentages for Eastern and Western Washington using the same regions that Premera used in its February 11, 2002 letter sent to Christine Gregoire, Esq., the Washington State Attorney General. These percentages were created using claims data that cover the period September 1, 2002 through June 30, 2003. The figure shows that Premera's reimbursements to physicians in Eastern Washington are about the same as its reimbursements to physicians in Western Washington. For example, the table shows that, during the period September 2002 to June 2003, Premera's reimbursements equaled [ ] percent of Medicare RBRVS payments in rural Eastern Washington and [ ] percent of Medicare RBRVS payments in rural Western Washington. Similarly, the table shows that, during the same period, Premera's reimbursements equaled [ ] percent of Medicare RBRVS payments in urban Eastern Washington and [ ] percent of Medicare RBRVS payments in urban Western Washington. Given that Western Washington is supposed to represent a competitive market for physician

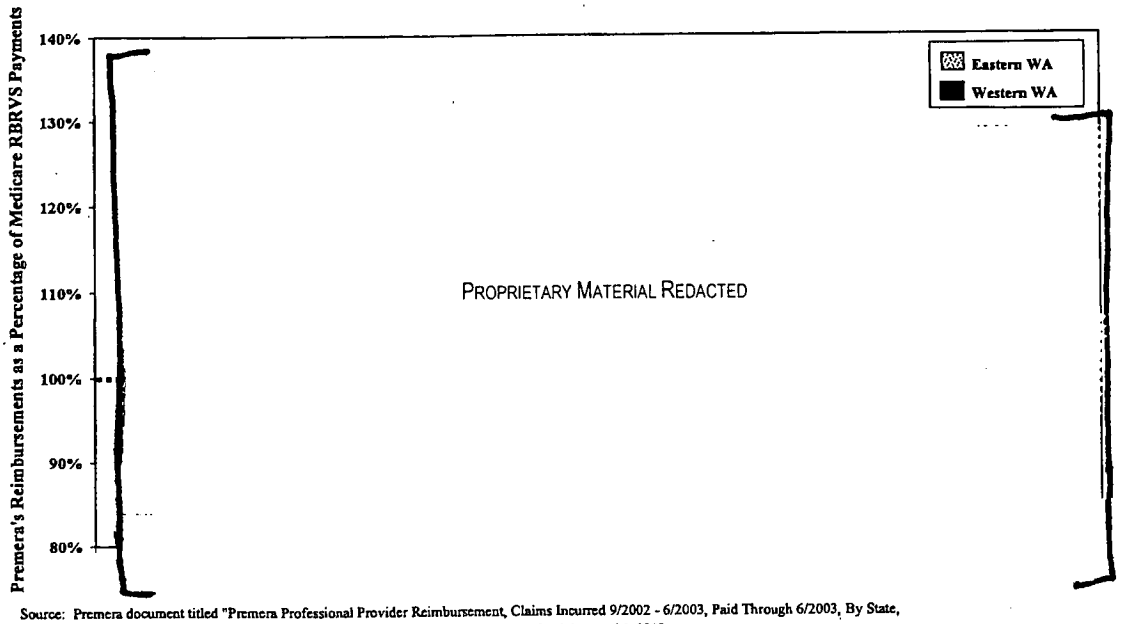
PROPRIETARY MATERIAL REDACTED

PROPRIETARY MATERIAL REDACTED

PROPRIETARY MATERIAL REDACTED

PROPRIETARY MATERIAL REDACTED

Figure 2: Premera's Physician Reimbursements as a Percentage of Medicare RBRVS Payments, Western and Eastern Washington, 2002 – 2003



Source: Premera document titled "Premera Professional Provider Reimbursement, Claims Incurred 9/2002 - 6/2003, Paid Through 6/2003, By State, By County, By Specialty" for Standard and Non-Standard Fee Schedules, received August 14, 2003.

services and given that the percentages for Eastern Washington are about the same as those for Western Washington, these results support the conclusion that Premera does not have market power on the buying side of the market in Eastern Washington.[116]

One possible criticism of the above analysis is that Western Washington and Eastern Washington both may contain a number of separate relevant geographic markets for physician services within each of the regions. To address this possible concern, we calculated Medicare RBRVS reimbursement percentages for each of the HSAs and MSAs located in Western and Eastern Washington. Figure 3 presents the results for the HSAs.[117] The results show that, during the period September 2002 through June 2003, Premera's reimbursements in Eastern Washington were about the same as its reimbursements in Western Washington. In particular, the figure shows that Premera's reimbursements in Eastern Washington as a percentage of Medicare RBRVS payments ranged from a low of [ ] percent to a high of [ ] percent, whereas its reimbursements in Western Washington ranged from a low of [ ] percent to a high of [ ] percent.[118] The mix of results for the HSAs in each region is very similar.

PROPRIETARY MATERIAL REDACTED

PROPRIETARY MATERIAL REDACTED

PROPRIETARY MATERIAL REDACTED

PROPRIETARY MATERIAL REDACTED

The results for the MSAs are presented in Figure 4.[119] Like the HSA results, they show that Premera's physician reimbursements in Eastern Washington reflect about the same range of outcomes as its reimbursements in Western Washington during the September 2002 to June 2003

---

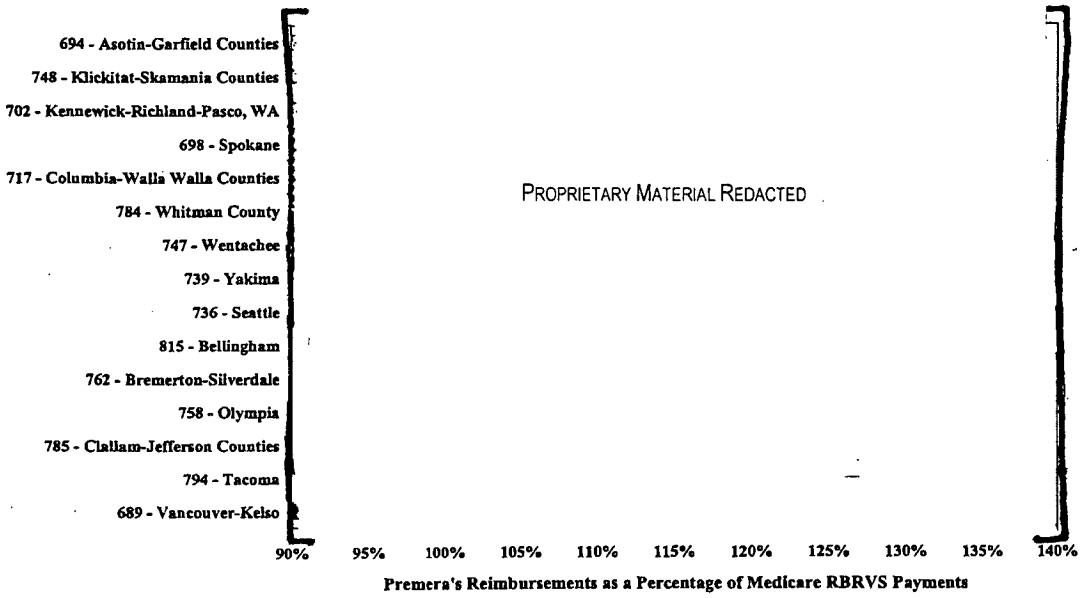
116 To verify that Premera's reimbursements in Eastern Washington are not significantly lower than its reimbursements in Western Washington, we once again relied upon regression analysis. The results of our analysis show that Premera's reimbursements in the two regions are not significantly different from each other, holding constant the difference in physician specialties. [See Table B-9 in Appendix B.] That is, the results show that Premera's reimbursements in Eastern Washington are not materially lower or higher than its reimbursements in Western Washington. We also estimated a variation of this regression where, instead of including a dummy variable for Eastern Washington, we included a separate dummy variable for every region but King County, whose effect is then captured by the intercept. The results of this regression show that Premera's reimbursements in King County are significantly lower than its reimbursements in all of the other regions, holding constant differences in physician specialties. [See Table B-10 in Appendix B.] These results further support the conclusion that Premera's reimbursements in Eastern Washington are not significantly lower than its reimbursements in Western Washington.

117 Figure B-1 is a map of the Washington HSAs. It is found in Appendix B.

118 To verify that Premera's reimbursement rates in the Eastern Washington HSAs are not significantly lower than in the Western Washington HSAs, we once again relied upon regression analysis. The results of this regression are qualitatively the same as for the region regression. [See again Table B-9 in Appendix B.] We also estimated a variation of this regression where we included a separate dummy variable for every HSA but the Seattle HSA. The results of this regression show that all of the HSAs but one have higher reimbursements than the Seattle HSA, and even that one HSA with lower reimbursements has a t-value that is almost equal to zero, indicating that the result has no statistical significance. [See Table B-11 in Appendix B.] Thus, these results further support the conclusion that Premera's reimbursements in Eastern Washington are not significantly lower than in Western Washington.

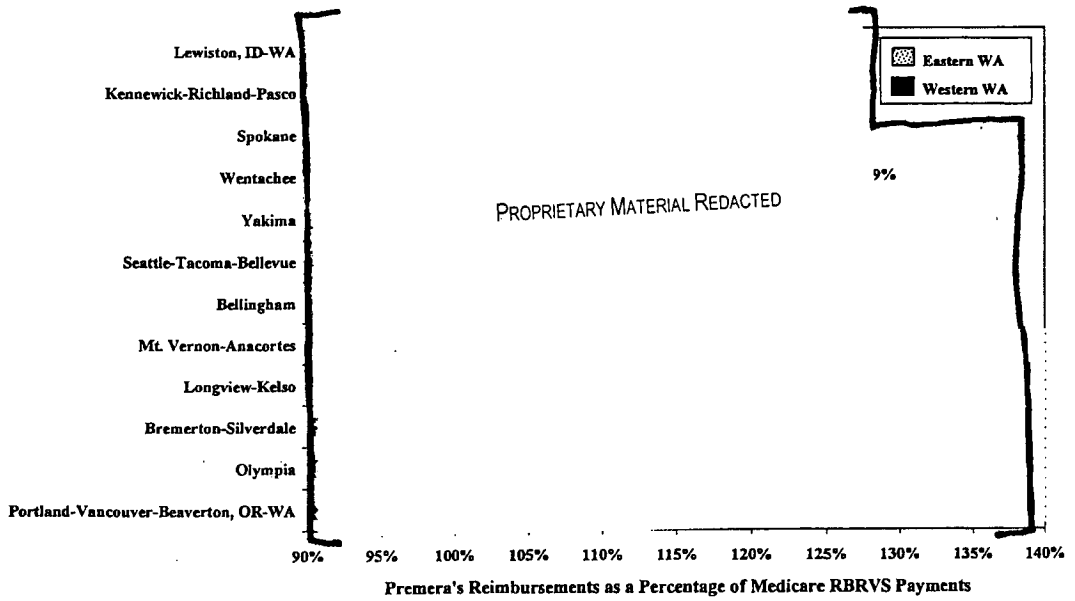
119 Figure B-2 is a map of the Washington MSAs. It is found in Appendix B.

Figure 3: Premera's Physician Reimbursements as a Percentage of Medicare RBRVS Payments, Based on Health Service Areas ("HSAs"), 2002 – 2003



Source: Premera document titled "Premera Professional Provider Reimbursement, Claims Incurred 9/2002 - 6/2003, Paid Through 6/2003, By State, By County, By Specialty" for Standard and Non-Standard Fee Schedules, received August 14, 2003.

Figure 4: Premera's Physician Reimbursements as a Percentage of Medicare RBRVS Payments, Based on Metropolitan Statistical Areas ("MSAs"), 2002 – 2003



Source: Premera document titled "Premera Professional Provider Reimbursement, Claims Incurred 9/2002 - 6/2003, Paid Through 6/2003, By State, By County, By Specialty" for Standard and Non-Standard Fee Schedules, received August 14, 2003.

PROPRIETARY MATERIAL REDACTED

PROPRIETARY MATERIAL REDACTED

period. For instance, the figure shows that Premera's reimbursements in Eastern Washington ranged from a low of [ ] percent to a high of [ ] percent, while Premera's reimbursements in Western Washington ranged from a low of [ ] percent to a high of [ ] percent. Thus, these results further support the conclusion that Premera does not have market power on the buying side of the markets for physician services in any part of the state.[120]

PROPRIETARY MATERIAL REDACTED

PROPRIETARY MATERIAL REDACTED

(2) Allowed Amounts per Claim

The second method we used to examine whether Premera has buyer-side market power was based on regression analysis. The basic model that we estimated consists of regressing the allowed amount per claim against an Eastern Washington dummy variable, the number of RVUs per claim, the area adjustment factor, and physician dummy variables for the different physician specialties. The Eastern Washington dummy variable is the key explanatory variable in this model. If the estimated regression coefficient for the Eastern Washington dummy variable is negative and statistically significant, this would indicate that Premera is paying Eastern Washington providers less and that it may have market power on the buying side in Eastern Washington. The number of RVUs per claim variable is another important variable. It controls for the difference in the intensity of services across claims. We expect that the estimated coefficient for this variable will be positive, indicating that the more resources that are required to render the services, the more the physicians will get paid per claim. The area adjustment factor is the same variable that Dr. Leffler used in his regression model. It is included to control for differences in provider costs and efficiency across geographic areas. Finally, the physician specialty dummy variables control for the specialization of the physicians.[121] Holding everything

---

[120] We once again relied upon regression analysis to verify that Premera's reimbursements in the Eastern Washington MSAs are not significantly lower than in the Western Washington MSAs. The results of this regression are the same as for the HSA regression. [See Table B-9 in Appendix B.] We also estimated a variation of this regression where we included a separate dummy variable for every MSA except for the Seattle MSA. The results of this regression are the same as for the HSA regression and they further support the conclusion that Premera's reimbursements in Eastern Washington are not significantly lower than in Western Washington. [See Table B-12 in Appendix B.] We also ran a similar regression using county level data. The results of this regression are basically the same as the other regressions. [See Table B-13 in Appendix B.]

[121] The specialties that we have controlled for consist of allergy (adult and pediatrics), cardiology (adult and pediatrics), cardiovascular surgery, colon-rectal surgery, dermatology, diabetes, emergency medicine, endocrinology, ear nose and throat (ENT), family practice, gastroenterology, general practice, general surgery, genetics, gerontology, hemotology, infectious disease, internal medicine, nephrology, neurology (adult and pediatric), neurological surgery, nuclear medicine, obstetrics-gynecology (OB-GYN), oncology, ophthalmology, orthopedic surgery, pathology (anatomical, clinical, and lab), pediatrics, neonatology, peripheral vascular, plastic surgery, podiatry/surgical chiropody, psychiatry, pulmonary diseases, radiation therapy, radiology, rheumatology, thoracic surgery, and vascular surgery.

else equal, we would expect the physicians with the most training and the greatest levels of specialization to be paid the most.

Table 17 summarizes the results of our regression analysis. They vary by the unit of observation (i.e., region, HSA, MSA, and county),[122] and they were estimated using the same data used to calculate the Medicare RBRVS percentages.[123] The results show that the explanatory variables collectively explain 98 percent of the variation in the premiums per member, i.e., the R-squares equal 0.98. This indicates that the explanatory variables are very helpful in explaining the differences we see in the allowed amount per claim across physician specialties. The results also

Table 17: Summary of Results for Physician Reimbursement Regressions, Based on Allowed Amount per Claim

Dependent Variable: Medicare RBRVS Percentage

Coefficients / (t-statistics)

	Regression Results			
Explanatory Variable	**By Region**	**By HSA**	**By MSA**	**By County**
Constant				
Eastern WA Dummy Variable		PROPRIETARY MATERIAL REDACTED		
R-Square				
F-Statistic				
Observations				

* Significant at 5 percent level.
** Significant at 1 percent level.

Note: This is a fixed effects regression model. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

[122] The unit of observation indicates the geographic level at which the variables were compiled. The MSA results indicate that the variables were compiled at the MSA level. That is, each observation indicates the allowed amount per claim and number of RVUs per claim for a given physician specialty in a given MSA. The different geographic levels represent the various possible geographic markets that have been proposed. Although we do not believe that single counties represent separate relevant geographic markets, we tested the model using county level data to address this assertion, as offered by Dr. Leffler.

[123] The only exception is that the data also include the area adjustment factors for the Small Group Filing effective May 1, 2002. These are the area adjustment factors that were in effect for most of the period in question.

show that the most important explanatory variable is the number of RVUs per claim, i.e., the estimated regression coefficient for this variable always has the highest t-value in absolute value terms. This indicates that the more services that the physicians rendered per claim, the more that they got paid per claim. Finally, the results show that the estimated regression coefficient for the Eastern Washington dummy variable is positive in sign (not negative, as would be expected if Premera were exercising monopsony power in Eastern Washington) but always has a t-value that is insignificant and always less than one in absolute value terms. This indicates that Premera's reimbursements to physicians in Eastern Washington are not materially higher or lower than its reimbursements to physicians in Western Washington. These results support the conclusion that Premera does not have market power on the buying side in Eastern Washington.[124,125]

4. Conclusion

All of the information set forth above demonstrates that Premera does not have market power on the buying side of any of the relevant provider markets and that, therefore, those markets are competitive in both their structure and their performance. In particular, the results of the market structure approach show that there are a number of structural factors (e.g., number and size of other payers, entry and expansion conditions of commercial insurers, countervailing negotiating strength of providers, and entry and exit conditions of providers) that constrain Premera to pay competitive reimbursement rates. Similarly, the results of the competitive effects approach confirm this conclusion by showing that Premera's reimbursement rates in Eastern Washington are not significantly lower than in Western Washington. This is true regardless of whether the rates are analyzed at the region, HSA, MSA, or county level.

Dr. Leffler, in contrast, has reached a different conclusion. In particular, he has concluded that Premera not only has market power on the buying side of the relevant provider

---

[124] We also estimated a variation of these regressions that involved using area dummy variables for the different regions, HSAs, MSAs, or counties instead of an Eastern Washington dummy variable. In all cases the excluded area dummy variable represented King County/Seattle. The results of these regressions further support the conclusion that Premera's reimbursements in Eastern Washington are not significantly lower than its reimbursements in Western Washington. [See Tables B-14 to B-17 in Appendix B.]

[125] Finally, we also estimated regressions based on the top 25 CPT code information that Premera provided the OIC. The model for these regressions is structured after the model for allowed amount per claim regressions. The only difference is that we include CPT dummy variables to control for the difference in the intensity of services across the different claims. The results of these regressions support the conclusion that Premera's physician reimbursement rates in Eastern Washington are not materially different than its physician reimbursement rates in Western Washington. [See Table B-18 in Appendix B.] In addition, a variation of these regressions, which includes area dummy variables instead of an Eastern Washington dummy variable, further supports this conclusion. [See Tables B-19 and B-20 in Appendix B.]

markets in Eastern Washington, but that it has actually been exercising that market power.[126] His conclusion appears to be based primarily on four findings: (1) that Premera's share of the insurance business in specific counties in Eastern Washington is much larger than its share in Western Washington counties, (2) that there is a negative and sometimes statistically significant relationship between Premera's reimbursement amounts and its share, (3) that Premera's physician reimbursement rates in Spokane are [ ] percent and [ ] percent lower than the First Choice and Regence rates, respectively, and (4) that the ratios of Premera's area adjustment factors for its traditional and PB products in Eastern Washington are lower than the corresponding ratios in Western Washington. An examination of each of these findings reveals, however, that they either are consistent with competition or they are not robust when tested using more appropriate or more complete data.[127]

PROPRIETARY MATERIAL REDACTED

PROPRIETARY MATERIAL REDACTED

First, although we agree with Dr. Leffler that Premera's share of the insurance business in Eastern Washington is generally higher than it is in Western Washington, we differ with how this information should be interpreted. Dr. Leffler views it as evidence that Premera has market power on the buying side in Eastern Washington. We view it as evidence that Premera and its predecessor company have been more successful over time by having invested much more time and money in developing a presence in Eastern Washington than have the other insurers to date. Eastern Washington is simply not as attractive a market to serve due to its lower population density and its high proportion of heavily regulated small group buyers. It is harder for a large number of health plans to succeed, so shares will tend to be higher, on average. But this does not mean that premiums or reimbursements are not at competitive levels, as our regressions demonstrate. Without stronger evidence that competition has been harmed in the provider markets, Premera's higher share in Eastern Washington simply reflects the success of its investments. There is nothing anticompetitive about it by itself. Moreover, we agree completely with Dr. Leffler's warning that, "[e]ven if a particular firm currently dominates a market, this

---

126 See Report of Keith Leffler, Ph.D., p. 4 ("The analysis does support the existence of some market power and some exercise of that market power by Premera in setting reimbursement rates in areas where it has market dominance.")

127 Another problem with Dr. Leffler's conclusion is that he has not examined whether the quantity of input use has been reduced. As explained above, a reduction in reimbursement rates is a necessary but not sufficient condition for demonstrating that a firm has market power on the buying side. A researcher must also show that the quantity of input use has been reduced to complete the analysis of buyer-side market power.

does not imply that the seller has market power."[128] A high market share by itself is not sufficient for demonstrating that a firm has market power.

In addition, as mentioned earlier, we believe that Premera's share of the fully-funded commercial insurance business is not even the correct share to be looking at when evaluating whether Premera has market power on the buying side. It is our experience from working on numerous matters that most providers earn a positive contribution margin from treating the traditional Medicare and (less so) Medicaid patients since the providers typically have a fair amount of excess capacity.[129] As a result, most providers will actively compete for the traditional Medicare and Medicaid patients even though these patients are not always as profitable as the commercial patients. This means that these patients should be included in the share calculations since they represent an alternative source of patients that the providers could turn to if they thought Premera was not paying them enough. As Table 2 of Dr. Leffler's Report shows, adding the traditional Medicare and Medicaid patients to the share calculation drops Premera's share in Eastern Washington from 53.7 percent to 22.8 percent.

Second, although we agree with Dr. Leffler that empirically testing whether Premera has market power on the buying side is superior to inferring it from a comparison of market shares, he did not use the data necessary and appropriate to fully perform this statistical analysis. In particular, Dr. Leffler should have used *allowed* amounts instead of *paid* amounts and he should have controlled for the intensity of services associated with each claim.[130] We also believe that he should have examined more provider specialties than the three that he did. Using the same type

---

[128] See Report of Keith Leffler, Ph.D., p. 17. This is one of the major problems with the PwC Economic Impact Report. When trying to argue that the conversion and the implementation of the Dimensions product will result in Premera obtaining and exercising market power on the selling side of the health insurance market, PwC's only evidence is that Premera has a high market share in many of the Eastern Washington counties. As mentioned earlier, even Dr. Leffler disagrees with PwC's conclusion regarding the health insurance market.

[129] A positive contribution margin means that the net revenues that the provider earns from treating a patient exceed the variable costs of providing the treatment.

[130] For example, Dr. Leffler's regressions involving hospital outpatient claims are particularly troubling. These claims can differ dramatically in the intensity of services embodied in the mix of claims. For instance, they can vary from simple lab work (e.g., drawing blood) to complicated invasive procedures (e.g., cardiac catheterizations). Without controlling for the intensity of services, there is no way to know how to interpret his conclusions comparing Western and Eastern Washington hospitals. For instance, it seems very plausible that, on average, the hospitals in Eastern Washington might provide less intensive outpatient services/procedures than the hospitals in Western Washington since they are generally much smaller facilities. Therefore, Dr. Leffler's finding that Premera's paid amount per outpatient claim is negatively related to Premera's share may only reflect that Premera has a relatively larger presence in Eastern Washington than in Western Washington and that the outpatient services/procedures being rendered in Eastern Washington are less intense than the ones being rendered in Western Washington. Based on our findings, his result may have nothing to do with whether Premera has buying-side market power in Eastern Washington.

of data that Dr. Leffler used but for a slightly different time period, we were able to approximately replicate the results for his Total Groups PCP regression shown on Table 4-B of his report.[131] [See Table 18.] However, when we controlled for the intensity of services associated with each claim and when we replaced the paid amounts with the allowed amounts, we not only caused a dramatic drop in the significance level of his share variable, but the sign of the relationship also

Table 18: Replication and Revision of Dr. Leffler's PCP Regression for Total Groups

Regression Results				
Coefficients / (t-statistics)				
Dependent Variable:	**Paid Amount per Claim**		**Allowed Amount per Claim**	
Explanatory Variable	**Replication**	**Controlled for Intensity of Services**	**Replaced Paid Amounts with Allowed Amounts**	**Controlled for Additional Specialities[1]**
Constant	PROPRIETARY MATERIAL REDACTED			
Combined Share				
Area Adjustment Factor				
RVUs per Claim				
R-Square				
F-Statistic				
Observations				

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: PCPs are defined as Family Practice and General Practice.
"na" indicates not applicable.

1 This is a fixed effects regression model. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

131 The data that we used to replicate Dr. Leffler's regression results are the same data that we used to estimate our physician reimbursement regressions. The only exception is that we also used the combined shares listed in Table 1D of Dr. Leffler's report. For purposes of Table 18, we considered Family Practice and General Practice to represent PCPs. However, if we also consider Internal Medicine to represent PCPs, the results remain basically the same. [See Table B-21 in Appendix B.]

changed from negative to positive, indicating that payments were not lower in Eastern Washington. [See again Table 18.] Adding additional physician specialties further weakened Dr. Leffler's results regardless of what share measure was used. [See again Table 18.] Moreover, Dr. Leffler's statistical methodology is still only an inferential approach since it is not directly comparing whether Premera's physician reimbursements in Eastern Washington are significantly lower than in Western Washington. Performing this more direct analysis provides further evidence that Premera does not have market power on the buying side in Eastern Washington. [See again Table 18.]

Third, even if Premera does have lower reimbursement rates than First Choice and Regence in Spokane, this is not necessarily evidence that Premera has market power. Premera could have lower reimbursement rates because it pays its physicians quicker and the physicians have fewer administrative hassles in dealing with Premera. Moreover, the available information indicates that Regence's reimbursement rates are higher than Premera's reimbursement rates even in Western Washington – although the percentage difference is not as large.[132] In addition, Dr. Leffler mentions in footnote 89 of his report that Group Health's reimbursement rates for all codes are only slightly higher and that its rates for the top 25 codes are no different. This suggests that Premera's reimbursement rates are not necessarily lower than its competitors. Finally, the fact that an insurer can get lower reimbursement rates in return for directing greater volume to a provider is quite common and is generally considered procompetitive. The economics literature refers to this practice as "selective contracting"[133] and many researchers credit it as being one of the major reasons why managed care has been able to help control the increase in health care costs.[134]

Fourth, in describing the comparison of the ratios of the area adjustment factors, Dr. Leffler suggested that one of the reasons why the comparison was meaningful was because the Traditional network contains many more providers than the Prudent Buyer network.[135] This

---

[132] In addition, PwC suggests that Regence's reimbursement rates in Western Washington are about 5 percent higher than Premera's. [PwC's Economic Impact Report, p. 45]

[133] See, e.g., Melnick, G., J. Zwanziger, and A. Verity-Guerra, "The Growth and Effects of Hospital Selective Contracting," *Health Care Management Review* (Summer 1989), pp. 57-66; see also Melnick, G., J. Zwanziger, A Bamezai, and R. Pattison, "The Effects of Market Structure and Bargaining Position on Hospital Prices," *Journal of Health Economics* 11 (1992), pp. 217-233.

[134] See, e.g., Dranove, David, *The Economic Evolution of American Health Care* (New Jersey, Princeton University Press, 2000), Chapter 4.

[135] See Report of Keith Leffler, Ph.D., p. 36.

ignores the fact that obtaining larger discounts in return for greater volume is common and considered to be procompetitive. Moreover, Table 3 in Dr. Leffler's report shows that the Eastern Washington result is driven in large part by the area adjustment factor for the Traditional product in Spokane. Without the Spokane result, the difference in the ratios would drop from [ ] percent [PROPRIETARY MATERIAL REDACTED] to only [ ] percent [PROPRIETARY MATERIAL REDACTED] In addition, if you limit the comparison to include Other W WA only, the difference in the ratios would drop further to only [ ] percent [PROPRIETARY MATERIAL REDACTED] Clearly, a [ ] percent difference is not compelling evidence of market power.

B. The Proposed Conversion Will Not Change the Current Market Conditions in the Provider Service Markets

Having demonstrated that Premera does not have market power on the buying side in any of the relevant provider markets, the only way the proposed conversion could substantially lessen competition in those markets is if it somehow allowed Premera to control those markets in a way it could not prior to the conversion. For this to take place, Premera would have to drive the other commercial buyers from those markets, again perhaps by charging extremely low premiums, and thereby winning all of the health insurance business in those markets. However, since it is fairly easy for commercial insurers to expand from one part of the state to another, Premera would not only have to drive the other commercial insurers out of those local provider markets but it would also have to drive them out of Washington and out of business altogether. Otherwise, those commercial insurers could just retreat to other parts of the state and move back in if Premera were to raise its premiums to supracompetitive levels. Moreover, in addition to having to drive the other commercial buyers out of business, Premera would also have to prevent new commercial insurers from entering. As discussed earlier, both possibilities are highly unlikely. This is because (1) Premera currently faces two large competitors that have about the same share of the health insurance business as Premera does, (2) Premera currently faces a number of other companies that include many of the largest insurers in the country, and (3) there are no significant barriers to entry that would prevent other insurers from entering the state if the economic incentive were to arise.

In conclusion, there is no evidence that Premera has buyer-side market power in any provider services market in Washington. Moreover, the competitive structure of the markets that Premera competes in on both the selling side (i.e., the health insurance market in Washington) and on the buying side (i.e., the provider services input markets throughout Washington) ensures that

Premera will continue to be constrained in both its pricing and its provider reimbursements, even after the proposed conversion.

Both Dr. Leffler and PwC appear to have reached the opposite conclusion from us with respect to the competitive nature of the provider services markets at issue. In particular, they appear to believe that the conversion, together with the implementation of the Dimensions products, is going to increase Premera's market power in the provider markets in Eastern Washington.[136] As evidence, PwC points to the fact that the difference in area adjustment factors between Eastern Washington and Western Washington is expected to increase with the implementation of the Dimensions products. However, PwC apparently does not understand that the change in the area adjustment factors has nothing to do with a reduction in provider reimbursement rates. Instead, it only reflects that Premera expects to be able to send more of its members in Eastern Washington to a smaller group of relatively cost effective providers. The Dimensions products are based on a tiering structure where the different tiers reflect differences in provider total health care costs. The change in the area adjustment factors only reflects the anticipated success of this tiering structure and it does not represent evidence that the proposed conversion is going to substantially lessen competition in the provider services markets.

[136] *Ibid.*, p. 4 ("The analysis conducted herein indicates that Premera has some market power with respect to provider reimbursements in certain regions of Washington. While that market power may be fully exploited under the current regional reimbursement and contracting procedures, such procedures can be changed by Premera to more fully exploit its market power.") and PwC's Economic Impact Report, pp. ES-8-ES-9 ("Premera's market dominance affects its relations with providers, with Eastern Washington providers receiving generally lower payment amounts...Geographic area rating factors suggest provider network payments are 5% to 14% lower in Eastern Washington for the current Premera products and that the difference may increase to 10% to 15% under the Dimensions products.")

V. The Proposed Conversion Will Not Reduce Access

In this report, we address three possible adverse economic impacts raised by the proposed conversion. The first two adverse impacts are that the proposed conversion might cause premiums to increase or reimbursement rates to decrease from competitive levels. As explained above, we have concluded that neither adverse impact will likely occur. A third possible adverse impact of the proposed conversion is that it might reduce consumer access to either health insurance products or health care providers. According to the public forums held to discuss this conversion, there appears to be some worry that the conversion will make Premera more concerned about its margins and financial viability and, as a result, Premera might cut back on the lines of business, the types of products, or the geographic areas in which it now sells. If so, this might reduce consumer access to both health insurance products and health care providers.

This concern about possible access problems appears to be based on the assumption that Premera has not been worried about its bottom line in the past and that, as part of its not-for-profit mission, it has subsidized certain lines of business, geographic areas, and/or health products that it felt were not profitable just so that access would not be harmed. To determine if this has been the case, we examined whether Premera has ever pulled out of any lines of business, geographic areas, and/or health products because competitive forces constrained whatever other goals Premera might have had as a not-for-profit company. If Premera has pulled out to avoid losses or to maintain margins, this would tend to refute the assertion that, as a not-for-profit, Premera has not been less concerned about its bottom line. In fact, vigorous competition like that found in the Washington health insurance market forces all firms, whether not-for-profit or for-profit, to watch their bottom line and to do what they can to replace their capital assets if they are to continue to be a viable, going concern into the future. If anything, Premera has been presented with challenges in maintaining its positions as a strong and stable competitor, and the need for access to capital that will allow Premera to do so in the future is a primary reason for the conversion.

On the issue of access, the results of our analysis show that Premera has often been forced by financial and competitive pressures to pull out of several lines of business and geographic areas in the past. For example, like other for-profit and not-for-profit insurers in the state, Premera stopped selling new health insurance polices to individuals in 1998 because it was losing

millions of dollars in that line of business.[137] Regence and Group Health (both not-for-profit companies) also stopped selling this product. All three companies ventured back into the individual business only after regulatory changes were made by the state. Similarly, like many not-for-profit and for-profit insurers in Washington and nationwide, Premera pulled out of the Medicare managed care business altogether in 2002 because that business became unprofitable in the face of Medicare cutbacks. However, even before it pulled out of the Medicare managed care business altogether, Premera had cut back on the number of counties it served. [See Table 19.]

Table 19: Premera's Service Areas for Selected Products, 1997 - 2003

	Number of Counties Where Product Is Offered						
Product	1997	1998	1999	2000	2001	2002	2003
Medicare Managed Care	7	7	7	6	1	0	0
Healthy Options	25	30	29	18	10	10	10
Basic Health Plan	25	30	29	18	11	11	11

Sources: CMS website, "Medicare Managed Care Market Penetration, Quarterly State/County/Plan Data Files" for December 1997-2002 and Premera data.

In addition, Premera has had to cut back on the number of counties in which it offers its Healthy Options and Basic Health Plan products.[138] [See again Table 19.] From our discussions with senior management, we have learned that Premera made those decisions because the Healthy Options and Basic Health Plan products were losing money in those counties. Finally, we also learned that Premera has stopped offering its HealthPlus HMO product because it believed that the product was not sufficiently profitable. All of this information supports the conclusion that Premera has already had to be very concerned about raising its margins, maintaining its required surplus, and replacing the capital it needs to function and to continue to grow. Its conversion to for-profit status will not free it from this burden nor make it watch the bottom line any more closely than it has been forced by competition to do as a not-for-profit company. Premera will still continue to operate only in those areas that it considers to be profitable.

Despite Premera's need to be equally concerned about its financial viability as a for-profit company or as a not-for-profit company, there are good business reasons that suggest that it is

[137] Associated Press Newswire, "Carriers Again Offer Individual Policies," December 3, 2000.

[138] PwC reports that Premera is exiting the PEBB as of January 1, 2004. [PwC's Economic Impact Report, p. 72]

very unlikely that access will change significantly after the conversion. Premera has made substantial investments in building a broad provider network throughout the state of Washington. Senior management tells us that this broad provider network is important to the company's business model. It provides a meaningful competitive advantage that allows Premera to compete effectively for contracts with large multi-site employers that may need insurance coverage in both urban counties and rural counties in Washington. It is very unlikely that Premera would dismantle its network anywhere in the state and give up such an important selling point to large employers. Moreover, once a network has been established, the fixed costs of setting up and maintaining the network can be economically spread over multiple lines of business, such as individual coverage and small group coverage. Thus, the costs of offering additional lines of business are less and, likely would still be offered.

A second business reason to maintain a statewide network is that Premera does not want to risk giving up its rights to the Blue marks in any area of its service territory under the BCBS Association rules. This might happen if there were to be a challenge that a specific county or set of counties is not being served and, thus, is not available to out-of-state Blues plans that may need national account coverage under the Blue Card system.[139] If such coverage were not available from Premera, another Blue plan (e.g., Regence) can apply to offer Blue coverage in the "abandoned" county.

It is also very unlikely that the conversion would cause Premera to pull out of the large group, small group, or individual businesses altogether. As mentioned earlier, if a carrier pulls out of any of those lines of business in a state as a whole, HIPAA prevents the carrier from re-entering those lines of business for five years.[140] Given the large investments that Premera has made to compete in the health insurance business in the state of Washington, it seems very unlikely that Premera would ever want to put itself into a position where it was prevented from competing in a particular commercial line of business for at least several years.

---

[139] The Blue Card system is an agreement among all the Blue Cross and Blue Shield plans that allows a Blue plan in another state (e.g., Minnesota) to sell a national account to a company headquartered in its state (e.g., the 3M Company) for coverage anywhere that the company has employees (e.g., in a rural mining area in Washington). The "local" Blues plan (in this example, Premera) has an obligation to provide access to provider contracts and a provider network in its territory. If coverage is not provided, the BCBS Association could intervene to assure that some Blue plan covers the "abandoned" county.

[140] When Premera stopped selling new health policies to individuals in 1998, the HIPAA regulation did not affect Premera since the company continued to service its existing individual policy holders.

In its report, PwC makes the assumption that the conversion from not-for-profit status to for-profit status will cause Premera to be more concerned about its bottom line and that this may lead to access problems.[141] However, PwC provides no evidence that the conversion is likely to change Premera's behavior. It only "assumes" that it will be the case. As mentioned earlier, economic theory teaches that, even though a not-for-profit firm may behave differently than a for-profit firm under some circumstances, it may also behave exactly the same.[142] The outcome depends on the goals of the not-for-profit firm and the constraints imposed by the competitive environment in which it operates. Therefore, the question of whether the conversion will change Premera's behavior and, thus, possibly lead to an access problem, is an empirical question that cannot be answered by theory or supposition alone. Moreover, the available information discussed above indicates that Premera has been concerned about improving its financial viability for a long time and, in that respect, has already been behaving like a for-profit company. The conversion is not going to change this competitive imperative. In addition, PwC has concluded that Premera has market power in the provider markets in Eastern Washington and that Premera has been exercising that market power. Although we disagree with PwC's findings, it is worth noting that if its findings were correct, this would further support the conclusion that Premera has already been operating like a for-profit company.

In contrast to PwC, the economists retained by the insurance authorities in the CareFirst and Blue Cross Blue Shield of North Carolina ("BCBSNC") conversions examined whether those proposed conversions would likely change the behavior of the Blue plans in question and, therefore, possibly lead to an access problem. In particular, the economists in the CareFirst matter examined this issue by empirically estimating what effect, if any, prior HMO conversions have had on premiums and reimbursements. They found that prior conversions have resulted in premiums *decreasing* slightly and provider reimbursement remaining basically the same.[143] From

---

141 PwC's Economic Impact Report, p. ES-7 ("As a for-profit company, Premera would have greater incentive to exit these programs if financial performance deteriorates.") Note that on page 7 of his report Dr. Leffler also assumes that the conversion will cause Premera to change its behavior, although he does not directly discuss the access issue ("For the purpose of this analysis I will assume that conversion to for-profit status will create pressures on Premera to raise premiums and lower provider reimbursements").

142 See, e.g., W. Lynk, "Property Rights and the Presumptions of Merger Analysis," *The Antitrust Bulletin* (Summer 1994), pp. 363- 383; see also J. Simpson and R. Shin, "Do Nonprofit Hospitals Exercise Market Power?" *International Journal of the Economics of Business* Vol. 5, No. 2 (1998), pp. 141-157.

143 See R. Feldman, D. Wholey, and R. Town, "The Effect of HMO Conversions to For-Profit Status," Final Report, February 3, 2003, p. 2. Note that they also found a one-time increase in hospital payments two years before a conversion. [p. 2.]

these results, they concluded that HMO conversions generally do not have any meaningful effect, pro or con, on competition or access.[144]

The economists in the BCBSNC conversion took a slightly different approach. Instead of empirically testing whether past conversions have changed plan behavior and have led to access problems, they conducted interviews with market participants. They found that most market participants felt that there was little change in the plans' behavior in pricing, underwriting, and product offerings after the conversions took place.[145] They also found that most market participants felt the primary drivers in the plans' behavior are the competitive market forces and regulatory rules, rather than organizational form or corporate culture.[146] Based on their interviews, they concluded "that conversions don't have a strong or consistent negative effect on affordability or accessibility."[147]

To further examine whether the proposed conversion is likely to change Premera's behavior and thus lead to an access problem, we empirically tested whether the not-for-profit insurers in Washington charge significantly lower premiums than the for-profit insurers in the state. The regression model that we used is basically the same as the one that we used to examine whether Premera's premiums are significantly higher than its competitors. The only difference is that instead of including a Premera dummy variable, we now include a not-for-profit dummy variable. If the estimated regression coefficient for this not-for-profit dummy variable is negative and statistically significant, this would suggest that the not-for-profit insurers may behave differently than their for-profit competitors, at least with respect to premiums, by charging lower premiums.

Table 20 summarizes the regression results. The results are basically the same as those described above in Section III.A.3.a. In particular, they show that the explanatory variables collectively explain most of the variation in the premiums per member (i.e., the R-Square equals 0.98) and that the most significant explanatory variable is the medical costs per member (i.e., it

---

144 *Ibid.*, p. 2 ("Although health insurance markets are hugely complex, we were able to discover several patterns of behavior that appeared regularly among the converting HMOs. The results do not provide unequivocal evidence that HMO conversions are either beneficial or detrimental to the public interest.")

145 See OB GYN News, "Access, Care Unharmed by Blue Cross Conversions: Uninsured, Rates Have Not Risen," August 15, 2003; also, C. Conover and M. Hall, "Summary of Key Informant Interviews," Appendix B to their report prepared for the North Carolina Insurance Department, October 11, 2002.

146 *Ibid.*

147 See OB GYN News, "Access, Care Unharmed by Blue Cross Conversions: Uninsured, Rates Have Not Risen," August 15, 2003.

Table 20: Summary of Results for Not-For-Profit Regressions

Dependent Variable: Premiums per Member Coefficients / (t-statistics)		
	Plan Regressions	
Explanatory Variable	Year Dummies	Time Trend
Constant	PROPRIETARY MATERIAL REDACTED	
Medical Expenses per Member		
HMO Membership Percent		
Medicare Managed Care Membership Percent		
Medicaid Managed Care Membership Percent		
Not-For-Profit Dummy Variable		
R-Square		
F-Statistic		
Observations		

* Significant at 5 percent level.
** Significant at 1 percent level.

has the largest t-value in absolute value terms). In addition, the results show that the not-for-profit dummy variable is positive but not statistically significant. This finding supports the conclusion that the premiums for the not-for-profit insurers are materially no different than the premiums for the for-profit insurers, holding constant medical benefits, mix of membership, and inflation.[148] It also supports the conclusion that the proposed conversion is not likely to change Premera's behavior, at least with respect to premiums.

In summary, the results of our access analysis demonstrate that the proposed conversion is not likely to reduce access to either health insurance products or health care providers. Premera will continue to offer only those products and compete in those lines of business that make

[148] We also ran a sensitivity test controlling for what share of each insurer's membership is made up of Medicare Supplement members. The results of this test further support the conclusion that not-for-profit insurers do not behave any differently than for-profit insurers, at least with respect to premiums. [See Table B-22 in Appendix B.]

commercial sense. However, there are several good business reasons to expect that Premera will not drop its major lines of business or pull back from offering a statewide network. Premera will very likely continue to contract with providers in all of the counties in order to maintain its strong selling point to multi-site, statewide, and national employers of having a broad network and to meet the network adequacy requirements of maintaining such a network.

VI. Concluding Remarks

The focus of our analysis has been on whether the markets in which Premera competes are competitive. If they are competitive in their structure and performance, then the proposed conversion can have no impact on either the competitive outcomes in the markets or access to the markets. Premera will have no choice but to continue offering competitive premiums, reimbursement rates, and product offerings if it wants to remain an effective competitor. If it does not, it will lose business. This is true regardless of whether it is a not-for-profit or a for-profit company.

We believe that the analysis set forth above demonstrates that the health insurance and provider services markets in which Premera competes are competitive. Premera does not have market power on either the selling side or buying side of any of these markets and the proposed conversion is not going to change this. As a result, it is our conclusion that the proposed conversion will not "substantially lessen competition or tend to create a monopoly in the health coverage business" in the state of Washington. It is also our conclusion that the proposed conversion is very unlikely to reduce consumer access to either health insurance products or health care providers, nor have we identified any other adverse economic impact.

Appendix A – Background Information

A-1: Resume of Thomas R. McCarthy

A-2: Resume of Scott J. Thomas

A-3: List of Materials Relied Upon

NATIONAL ECONOMIC
RESEARCH ASSOCIATES
777 SOUTH FIGUEROA STREET, SUITE 4200
LOS ANGELES, CALIFORNIA 90017
TEL: 213.346.3000 FAX: 213.346.3030
INTERNET: http://www.nera.com

n/e/r/a
Consulting Economists

THOMAS R. McCARTHY

BUSINESS ADDRESS

Senior Vice President
National Economic Research Associates, Inc.
777 South Figueroa Street – Suite 4200
Los Angeles, California 90017
(213) 346-3005
thomas.mccarthy@nera.com

Dr. McCarthy received a B.A. in Economics from Assumption College in Worcester, Massachusetts and Master's and Ph.D. degrees in Economics from the University of Maryland under a National Defense Education Act Fellowship. After teaching microeconomic theory and urban economics at the University of Maryland, Dr. McCarthy joined the faculty of the School of Economics and Management of Oakland University in Michigan. There he taught graduate and undergraduate microeconomics as well as health economics, his area of special interest.

Dr. McCarthy joined NERA in 1983 and now directs NERA's health care practice in the U.S., a practice that specializes in the economic analysis of regulatory, public policy and litigation matters in health care markets. His own projects include analyzing the competitive effects of more than 100 health care industry mergers, including evaluating the horizontal and vertical issues created by mergers of hospitals, hospital systems, health insurers, physician groups, physician practice management companies, imaging and other medical device manufacturers, and home health care companies. In a variety of health care antitrust liability and damages cases, he has analyzed exclusive contracts, physician staff privileges issues, exclusions from managed care panels, alleged foreclosures due to shifting referral patterns, joint ventures, hospital and physician monopolization cases, and state action immunity issues involving certificates of public advantage covering recent hospital mergers in Montana and South Carolina. He has also analyzed class certification and liability issues in class action cases brought against HMOs. As part of his policy work, Dr. McCarthy has analyzed Medicare prescription drug proposals. He is also co-editor and a principal author of a year-long, two-volume study of health care reform in 12 industrialized countries, published by Kluwer.

Another area of specialization for Dr. McCarthy has been the economics of intellectual property protection, including the estimation of contract, trade dress, trade secret and patent damages, particularly for medical equipment and devices but also including computer hardware, CD-Rs, supermarket equipment, satellites, and agricultural products. He has also worked on

antitrust, damages, and class certification matters involving the pharmaceutical, soft drink, agriculture, candy, ice cream, auto parts, oil, video distribution, and newspaper industries. Other major projects include the development of affirmative action plans and the estimation of damages resulting from a major oil spill.

Prior to joining NERA, Dr. McCarthy was a staff economist with the Federal Trade Commission conducting studies of regulation and competition in health care markets. One such study examined the competitive effects of certificate-of-need regulation in the hospital market.

Dr. McCarthy has written several papers analyzing competition and antitrust damages in health care as well as on transportation issues in urban economics. These include an article in the *Journal of Health Economics* on competition in the physician services market and articles in recent or forthcoming ABA monographs on antitrust damages in health care cases, hospital merger efficiencies, monopoly and monopsony issues between payers and providers, and defining geographic markets in hospital mergers. Other research activities include presentations at professional meetings and his serving as an invited panelist or moderator for various health care policy conferences. He has also made presentations on such subjects as hospital mergers, health plan mergers, health care reform in the U.S. and around the world, "Tobacco II" class action litigation against HMO's, antitrust damages, wrongful termination, and the confiscation of intellectual property rights through price and profit regulation. Most recently, he was invited by the Federal Trade Commission and the Antitrust Division of the Department of Justice to testify at three different sessions about monopoly and monopsony issues in health care at their joint hearings on Health Care and Competition Law and Policy.

Dr. McCarthy is a member of the American Economic Association and an associate member of both the American Health Lawyers Association and the American Bar Association's Section of Antitrust Law, including membership with the Section's Health Care Committee. He also served on the American Bar Association's Task Force on Hospital Mergers.

EDUCATION

UNIVERSITY OF MARYLAND
Ph.D., Economics, 1980

UNIVERSITY OF MARYLAND
M.A., Economics, 1973

ASSUMPTION COLLEGE
B.A., Economics, 1971

CANISIUS COLLEGE, 1967-1969

EMPLOYMENT

11/96-present	NATIONAL ECONOMIC RESEARCH ASSOCIATES, INC. *Senior Vice President.* *Member, Board of Directors.*
11/89-11/96	*Vice President.*
2/86-11/89	*Senior Consultant and Project Director.*
12/83-1/86	*Senior Analyst.*
	FEDERAL TRADE COMMISSION
1982-1983	*Staff Economist*, Division of Regulatory Analysis, Bureau of Economics
	OAKLAND UNIVERSITY
1978-1982	*Assistant Professor*, School of Economics and Management
	BLUE CROSS/BLUE SHIELD OF MICHIGAN
1980-1982	*Consultant.*
	DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
1978-1980	*Sole-source Contractor*, Health Care Financing Administration
	UNIVERSITY OF MARYLAND
1975-1978	*Instructor*, Department of Economics
	GENERAL ELECTRIC TEMPO
1975-1978	*Consultant*, Center for Advanced Studies
	UNIVERSITY OF MARYLAND
1975	*Teaching Assistant*, Department of Economics
	UNIVERSITY OF MARYLAND
1971-1973	*National Defense Education Act Teaching Fellow.*

FELLOWSHIPS, AWARDS, MEMBERSHIPS

Wall Street Journal Award for Outstanding Achievement in Economics, Assumption College, 1971

Graduate Assistantship, University of Maryland, 1974-1975

National Defense Education Act Fellowship, University of Maryland, 1971-1974

Outstanding Faculty Award, Oakland University Chapter of the Golden Key National Honor Society, 1981

Member, American Economic Association

Member, American Health Lawyers Association

Associate Member, American Bar Association, including membership in Section of Antitrust Law and Health Care Committee

Member, ABA Task Force on Hospital Mergers

PUBLICATIONS

"Geographic Market Issues in Hospital Mergers," Chapter 3 (with Scott Thomas) in Douglas C. Ross and Mark J. Horoschak, *Health Care Mergers and Acquisitions Handbook*, Chicago: American Bar Association, 2003.

"Antitrust Issues Between Payers and Providers," (with Scott Thomas) prepared for the ABA-AHLA Health Care Antitrust Meetings, Washington DC, May 17-18, 2001. (Reprinted in two parts in *Antitrust Health Care Chronicle*, Chicago: American Bar Association, Spring 2002 and Summer 2002.)

"Efficiencies Analysis in Hospital Mergers," (with Scott Thomas and Lawrence Wu) *Antitrust Health Care Chronicle*, Volume 13, No. 1 (Winter 1999), pp. 2-11. (Revised version of article found in Howard Feller, *Antitrust and Healthcare Insights into Analysis and Enforcement*, Chicago: American Bar Association, Spring 1999.)

"Analyzing Damages in Health Care Antitrust Cases," (with Scott Thomas), *Antitrust Developments in Evolving Health Care Markets*, American Bar Association, 1996, pp. 67-96.

"Health Care Reforms – Are They Answering the Right Questions?" *Adapting a Global Industry to the New Health Care Environment*, Proceedings of the *Financial Times* World Pharmaceuticals Conference, March 23 and 24, 1994.

Financing Health Care, co-editor (with Ullrich Hoffmeyer), Kluwer Academic Press, 1994.

- Co-author, Chapter 2; "The Prototype" (with Ullrich Hoffmeyer)
- Co-author, Chapter 14; "The Health Care System of the United States" (with Julie Minnis)

"Health Care Funding and Its Impact on the Balance of Supply, Demand and the Meeting of Needs," *A New Socio-Economic Order in Twenty-First Century Europe*, Conference Proceedings of the General Assembly of the European Federation of Pharmaceutical Industries' Associations, 1993, pp. 47-54.

"U.S. Health Care Reform: NERA Offers a Number of Recommendations," (with Julie Minnis) *Viewpoint*, Vol. XXII, No. 1 (Winter 1993), pp. 15-21.

"The Effect of City Size on Journey to Work Behavior: Some Empirical Evidence" (with Oded Izraeli), *Perspectives in Urban Geography*, Volume V (Concept Publishing Company, New Delhi, India, 1987).

"The Competitive Nature of the Primary Care Physician Services Market," *Journal of Health Economics*, Vol. 4, No. 2 (June 1985).

"Variations in Travel Distance, Travel Times and Modal Choice Among SMSAs" (with Oded Izraeli), *Journal of Transport Economics and Policy*, May 1985.

"Beyond Goldfarb: Applying Traditional Antitrust Analysis to Changing Health Markets" (with Geraldine Alpert), *The Antitrust Bulletin*, Vol. 24, No. 2 (Summer 1984), pp. 165-204.

"Commentary," in *A New Approach to the Economics of Health Care*, Mancur Olson, ed., American Enterprise Institute, Washington, D.C. (December 1981). A review of four papers on Hospital Regulation presented at AEI conference on "Health Care-Professional Ethics, Government Regulation, or Markets," September 25-26, 1980.

CONFERENCE PAPERS AND PRESENTATIONS

"Health Insurance Monopsony – Competitive Effects," testimony and presentation to The Federal Trade Commission and The Department of Justice Antitrust Division, Hearings on Health Care and Competition Law and Policy, Washington, DC, April 25, 2003.

"Health Insurance Monopsony – Market Definition," testimony and presentation to The Federal Trade Commission and The Department of Justice Antitrust Division, Hearings on Health Care and Competition Law and Policy, Washington, DC, April 24, 2003.

"Contracting Practices," testimony and presentation to The Federal Trade Commission and The Department of Justice Antitrust Division, Hearings on Health Care and Competition Law and Policy, Washington, DC, March 27, 2003.

Economics v. Daubert: Roundtable and Moot Hearing, Moderator, NERA Seminar on Antitrust and Trade Regulation, Santa Fe, NM, July 6, 2002.

"Leadership in Challenging Times," Directors' Roundtable speech and discussion with the Honorable Timothy Muris, Chairman of the Federal Trade Commission, Los Angeles, CA, April 18, 2002.

"Antitrust Issues Affecting Payors," presentation and paper to conference on "Antitrust in Healthcare," sponsored by the ABA Section of Antitrust Law, the ABA Health Law Section, and the American Health Lawyers Association, Washington, D.C., May 17-18, 2001.

"Why Tobacco II: What Changes Do Plaintiffs Want in the Use of Financial Incentives in the Managed Care Industry?" Moderator and panelist at Marsh Health Spectrum Forum on Managed Care Organization Enterprise Risk, New Orleans, LA, July 13, 2000.

"Use of Economists – Help or Hindrance?" Workshop presentation at American Health Lawyers' Association conference on "Antitrust in the Healthcare Field," Arlington, VA, February 17, 2000.

"Aetna's Acquisition of Prudential Health Care," presentation at D.C. Bar Association luncheon, Washington, D.C., December 14, 1999.

"Restructuring and Competition in the Health Insurance Industry," presented at NERA Seminar on Antitrust and Trade Regulation, Santa Fe, NM, July 10, 1999.

"Efficiencies Analysis in Hospital Mergers," speech at the ABA Conference on Antitrust Issues in Health Care, sponsored by the ABA Section of Antitrust Law and the Section of Health Law, in New Orleans, LA, October 16, 1998.

"Restructuring and Competition in the Health Care Industry," presented at NERA Seminar on Antitrust and Trade Regulation, Santa Fe, NM, July 11, 1998.

"Overview of International Health Care Systems," presentation to the Eli Lilly and UCLA Anderson School of Business' 1998 Global Health Care Conference on "Managing Evolving Health Care," Los Angeles, CA, June 26, 1998.

"Current Antitrust Issues for Health Plans," presented to the American Association of Health Plans' 8th Annual Managed Care Law Conference, San Diego, CA, April 27-29, 1997.

"Certificates of Public Advantage: The Example of a Great Falls Hospital Merger," presented at NERA Seminar on Antitrust and Trade Regulation, Santa Fe, NM, July 4, 1996.

"Hospital Mergers and State Action Immunity," speech before the State Action/Noerr Doctrine Committee at the American Bar Association meetings of the Section of Antitrust Law, Washington, D.C., March 27, 1996.

"The Economics of Vertical Mergers," presented to Preston, Gates & Ellis Conference on "Antitrust: Does the Tiger Again Have Teeth?" Seattle, WA, May 5, 1995.

"Analyzing Damages in a Health Care Antitrust Case," presented at American Bar Association Conference on Antitrust and Health Care, co-sponsored by the Section of Antitrust Law and the American Bar Association Forum on Health Care, New Orleans, LA, October 7, 1994.

"Health Care Reforms Worldwide," presented at William M. Mercer International Conference, New York, NY, September 29, 1994.

"Employer Mandates in Health Care Reform," presented at NERA Seminar on Antitrust and Trade Regulation, Santa Fe, NM, July 7, 1994.

"Health Care Reforms – Are They Answering the Right Questions?" Speech to the *Financial Times* World Pharmaceuticals Conference entitled Adapting a Global Industry to the New Health Care Environment, London, U.K., March 23, 1994.

"Establishing the Relevant Market in Health Care Cases," presented at the National Health Lawyers Association meetings on Antitrust in the Health Care Field, Washington, D.C., February 18, 1994.

"Cost Crisis in Health Care: A Global Convergence Toward Market-Based Solutions," sponsored by The Center for Strategic and International Studies. The results of NERA's 16-volume study of health care reform in 12 industrialized countries were presented to Congressional staffs on September 15, 1993 in the Senate's Hart Building, Washington, D.C. (with U. Hoffmeyer and R. Rapp).

"The Implications of Health Care Reform for Antitrust Litigation," presented at NERA Seminar on Antitrust and Trade Regulation, Santa Fe, NM, July 10, 1993.

"Health Care Funding: It's Impact on the Balance of Supply, Demand and the Meeting of Needs," presented at the Annual Conference of the European Federation of Pharmaceutical Industries' Associations, Salzburg, Austria, May 25, 1993.

"Health Care Reform and the European Economic Community," presentation to representatives of various Directorates General of the European Commission, including Mr. Fernand Saur, in charge of pharmaceutical policy for the EC, Brussels, Belgium, May 13, 1993.

"Financing Health Care, with Particular Reference to Medicines," presentation of year-long study to CEOs of 35 R&D based pharmaceutical companies, Washington, D.C., April 1, 1993.

Discussant, "The Proposed Dutch Health Care System: Moving Away from Employer-Based Health Insurance," by Warren Greenberg, American Economic Association Meetings, Anaheim, CA, January 7, 1993.

"Effective Use of Economists in Health Care Litigation," presented at the National Health Lawyers Association meetings on Antitrust in the Health Care Field, Washington, D.C., January 29-31, 1992.

"Calculating Damages For Lost Earnings," presented at NERA Seminar on Calculating Economic Damages in Employment Cases, Los Angeles, CA, March 26, 1991.

"Valuing Intangibles in Transfer Pricing Cases," presented at NERA Seminar on Antitrust and Trade Regulation, Santa Fe, NM, July 7, 1990.

"Estimating Patent Infringement Damages," NERA Seminar on New Developments in the Economics of Patent Infringement Litigation, San Francisco, CA, and Los Angeles, CA, December 5 and 6, 1989.

"Competition and Cooperation in the Provision of Health Care," presented at NERA Seminar on Contracting in the NHS, London, UK, September 11, 1989.

"A Comparison of the Cluster of Services Approach with the Product Line Approach in Analyzing Hospital Mergers and Acquisitions," presented at NERA Seminar on Antitrust and Trade Regulation, Santa Fe, NM, July 1987 and Young Partners Luncheon Series, New York, NY, October 5, 1987.

"The Application of Franchising Concepts in the Health Care Industry," workshop presented to the Ninth Annual American Bar Association's Forum Committee on Franchising, San Antonio, TX, October 23-24, 1986.

"Misuse and Confiscation of Intellectual Property," presented at a NERA Seminar on Patents: The New Economics (Infringement, Misuse and Damages), New York, NY, April 17, 1986.

"Calculating Economic Damages in Wrongful Termination Cases," presented at the First Annual Employment Litigation Workshop sponsored by the *Employee Relations Law Journal*, Williamsburg, VA, September 18-20, 1985.

"An Economic Analysis of Certificate of Need Laws" (with David Kass), presented at the American Economic Association Meetings, San Francisco, CA, December 1983.

"Medical, Legal, and Economic Ramifications of Changes in the Health Care System," panelist at the American Enterprise Institute Conference on "Restructuring the Health Care Financing System: Policies and Programs" Washington, DC, January 26-27, 1983.

"A Reexamination of Medical Society Control of Blue Shield Plans," discussant of Arnould and Debrock paper at the Eastern Economic Association Meetings, Washington, DC, April 29, 1982.

"Public Policy Toward the Health Care Sector," presented to the Detroit Chapter of the National Association of Health Services Executives, Pontiac, MI, June 15, 1982.

Reviewer of four papers on "Regulation–Can It Improve Incentives?" at the American Enterprise Institute Conference on "Health Care–Professional Ethics, Government Regulation, or Markets?" Washington, DC, September 25-26, 1980.

"A Model of the Primary Care Physician Firm," presented at the Eastern Economic Association Meetings, Montreal, Canada, May 8-10, 1980.

Moderator, Conference on Physician Manpower Issues – Health Economists' Views (Reinhardt, Sloan), Oakland University Health Education Program, Rochester, MI, October 16, 1979.

DEPOSITION TESTIMONY

Rocky Mountain Medical Center v. Northern Utah Healthcare Corporation, et al., October 16, 2003.

Retractable Technologies, Inc. v. Becton Dickinson & Company, et al., August 25, 2003.

In the Matter of Certain Recordable Compact Discs and Rewritable Compact Discs (United States International Trade Commission Investigation), May 23, 2003.

McKenzie-Willamette v. PeaceHealth, April 17, 2003.

Del Monte Fresh Produce Company and Del Monte Fresh Produce N.A., Inc. v. Dole Food Company, Inc. and Dole Fresh Fruit Company, January 21, 2002.

Yvonne Green, on her behalf and on behalf of all others similarly situated, v. Aetna U.S. Healthcare, Inc., et al., October 26, 2001.

In Re: Aetna, Inc. Securities Litigation, June 21 and July 19, 2000.

Boston Scientific Corporation v. Mentor Medical, Inc., August 21, 1998.

The County of Tuolumne and Eric Runte v. Sonora Community Hospital, et al., October 2-3, 1997.

St. Mary Medical Group, Inc. v . M & C ProActive Management, Ltd., et al., April 18, 1997.

COBE Laboratories, Inc. v. AVECOR Cardiovascular, Inc., June 5, 1996.

Allergan Medical Optics and Microtech, Inc. v. Staar Surgical Co., Inc., May 28, 1996.

American Council of Certified Podiatric Physicians and Surgeons v. American Board of Podiatric Surgery and American Podiatric Medical Association, March 14, 1996.

Retina Associates, P.A. v. Southern Baptist Hospital of Florida, Inc., January 18-19, 1996.

Santa Cruz Medical Clinic and Derjjan Associates, Inc. v. Dominican Santa Cruz Hospital, September 5-6, 1995, October 3-4, 1995 and February 2, 1996.

Trylon Corporation v. Metwest, Inc. and Unilab Corporation, April 7, 1995.

Wang Laboratories, Inc. v. Mitsubishi Electronics America, Inc., et al., March 8, 1994 and June 8, 1994.

American Health Advisors and William Phillips v. The University of Texas System, et al., November 9, 1993.

John A. Bakos, M.D. v. Roseville Community Hospital, et al. and John A. Bakos, M.D. v. Donald Franks, M.D., et al., October 8, 1993.

Diasonics, Inc. v. Acuson Corporation, December 8-9, 1992, March 15 and March 24, 1993.

David B. Kaye, M.D., et al. v. California Eye Institute, et al., December 28-29, 1992.

Gerhard Flegel, D.O. and Richard Still, D.O. v. Christian Hospital Northeast-Northwest, et al., August 28, 1992.

Lawrence Leyba, D.O. v. Hartmut Renger, M.D., Anesthesia Specialists of Albuquerque and St. Joseph's Health Care Corporation, August 22, 1991.

Dan A. Morgenstern, M.D. v. Charles S. Wilson, M.D., et al., July 18-19, 1991.

Colorado Orthopedic Dance and Athletic Rehabilitation, P.C. and Linda Perkin v. Preferred Independent Physical Therapy Organization, Inc., October 4, 1990.

Jeanne Call, et al. v. Prudential Insurance Company of America, et al., September 5, 1990.

Weldotron Corporation v. Hobart Corporation and Waldyssa, S.A., March 6-9, 1990, April 30, 1990 and May 1-4, 1990.

AB Food Products, Inc. v. Fabrica de Chocolates La Azteca, The Quaker Oats Company and Gabriel Tello, January 3, 1990.

Thomas Andrew Cherewick and Therapeutic Radiology, P.S.C. v. Northern Rockies Regional Cancer Treatment Center, et al., February 9, 1989.

Dreyer's Grand Ice Cream, Inc. v. Popsicle Industries, Inc., Sara Lee Corporation, and DOES 1-100, December 9, 1988 and December 12, 1988.

Michigan State Podiatry Association, et al. v. Blue Cross and Blue Shield of Michigan and Eugene Harper, D.P.M., et al. v. Blue Cross and Blue Shield of Michigan, July 20 and 21, 1987.

Sun Drop Bottling Company, Inc., et al. v. Coca-Cola Bottling Co. Consolidated and Pepsi-Cola Bottling Company of Charlotte, Inc., January 30 and 31, 1986.

Wordsman v. Xerox Corporation, October 9, 1985.

TRIAL TESTIMONY

McKenzie-Willamette Hospital v. PeaceHealth (U.S. District Court, District of Oregon), October 22-23, 2003.

David M. Odom v. Fairbanks Memorial Hospital, et al. (Superior Court of the State of Alaska, Fourth Judicial District of Fairbanks), March 14, 2002.

St. Mary Medical Group, Inc. v. M & C ProActive Management, Ltd., et al., June 9, 1997.

Wang Laboratories, Inc. v. Mitsubishi Electronics *America, Inc., et al.*, (U.S. District Court, Central District of California), June 28, 1994.

American Health Advisors and William Phillips v. The University of Texas System, et al. (District Court of Travis County, Texas, 261st Judicial District), November 23, 1993.

Gil N. Mileikowsky, M.D. v. Sheldon L. Schein, M.D., et al. (Superior Court of the State of California, County of Los Angeles), October 25, 1993.

Dan A. Morgenstern, M.D. v. Charles S. Wilson, M.D., et al. (U.S. District Court, District of Nebraska), December 9-10, 1991 and September 8-10, 1992.

Sun Drop Bottling Company, Inc., et al. v. Coca-Cola Bottling Co. Consolidated and Pepsi Cola Bottling Company of Charlotte, Inc. (U.S. District Court, Western District of North Carolina), May 29-30, 1986.

ARBITRATION TESTIMONY

Trylon Corporation v. Metwest, Inc. and Unilab Corporation (binding arbitration before Judge Weil), April 19, April 21, May 29, 1995 and July 10, 1995.

TESTIMONY PROVIDED TO THE INTERNATIONAL TRADE COMMISSION

In the Matter of Certain Recordable Compact Discs and Rewritable Compact Discs (USITC Inv. No. 337-TA-474), Washington, DC, June 19, 2003.

TESTIMONY PROVIDED TO STATE AGENCIES

New Mexico Division of Insurance, Testimony in support of Cimarron Health Plan's acquisition of QualMed Plans for Health, Santa Fe, New Mexico, August 30, 1999.

Florida State Department of Insurance, (written) Testimony in support of Aetna, Inc.'s acquisition of Prudential Health Care's Florida Division, Tallahassee, Florida, March 2, 1999 and March 11, 1999.

New Mexico Division of Insurance, Testimony in support of Presbyterian Health Plan's acquisition of FHP of New Mexico, Inc., Santa Fe, New Mexico, October 23, 1997.

CERTIFICATE OF NEED HEARING TESTIMONY

Fact-finding hearing before Virginia State Department of Health on behalf of Brandermill Active Retirement Village, Inc. – Evaluation of the Virginia State Department of Health nursing home bed need methodology, October 9, 1986.

August 2003

NATIONAL ECONOMIC
RESEARCH ASSOCIATES
777 SOUTH FIGUEROA STREET, SUITE 4200
LOS ANGELES, CALIFORNIA 90017
TEL: 213.346.3000 FAX: 213.346.3030
INTERNET: http://www.nera.com

nera
Consulting Economists

Appendix A-2

SCOTT J. THOMAS

BUSINESS ADDRESS

National Economic Research Associates, Inc.
777 South Figueroa Street, Suite 4200
Los Angeles, California 90017
(213) 346-3004
scott.thomas@nera.com

Dr. Thomas received a B.A. *cum laude* in Economics from the University of California, Los Angeles, and M.A. and Ph.D. degrees in Economics from the University of California, Irvine. While in graduate school, he specialized in public choice, industrial organization, and econometrics. His graduate honors included a Regent's Dissertation Fellowship and an Outstanding Graduate Scholar Award.

At NERA, Dr. Thomas has worked on a variety of health care antitrust matters involving hospitals, physicians, insurers, trauma centers, home health providers, skilled nursing centers, laboratories, medical equipment distributors, ambulance companies, and pharmaceutical manufacturers. He has studied relevant markets, monopoly pricing, predatory practices, price discrimination, tying, vertical restraints, mergers and acquisitions, antitrust damages, and class certification issues. Dr. Thomas has also specialized in intellectual property matters involving the medical equipment and pharmaceutical industries. He has focused on the valuation of patents and trade secrets and the calculation of damages resulting from infringement.

In addition, Dr. Thomas has worked on a number of health care commercial damage matters involving hospitals, physicians, laboratories, and pharmaceutical manufacturers. He has applied econometric techniques and financial analysis to calculate damages for tortious interference, breach of contract, and wrongful injury/termination cases. Finally, Dr. Thomas has performed valuations of various businesses, including hospitals and physician practices. He has used strategic projections, financial statements, and stock price data to assess the market value of these entities.

Before joining NERA, Dr. Thomas served on the faculty at the University of California, Irvine. He taught introductory macroeconomics, intermediate macroeconomics, and intermediate microeconomics. His research focused on information and advertising: bill sponsors as voting cues, stock market reaction to unanticipated legislation, and negative advertisements and voter turnout.

Dr. Thomas has published several articles on economic theory and econometrics in refereed journals. He has also written several papers for the American Bar Association on "Efficiencies Analysis in Hospital Mergers" and "Analyzing Damages in Health Care Antitrust Cases."

He is a member of the American Economic Association and Western Economic Association and an associate member of the American Health Lawyers Association and the American Bar Association's Antitrust and Health Law Sections.

EDUCATION

UNIVERSITY OF CALIFORNIA, IRVINE
Ph.D., Economics, 1989
M.A., Economics, 1987
Areas of Concentration: Public Choice
Industrial Organization
Econometrics
Honors: Outstanding Graduate Scholar Award, 1989
Regent's Dissertation Fellowship, 1988-1989

UNIVERSITY OF CALIFORNIA, LOS ANGELES
B.A., Economics, 1979
Honors: Graduated *Cum Laude*

PROFESSIONAL EXPERIENCE

NATIONAL ECONOMIC RESEARCH ASSOCIATES, INC.

3/99-present *Vice President.*

2/93-3/99 *Senior Consultant.*

7/90-2/93 *Senior Analyst.*

UNIVERSITY OF CALIFORNIA, IRVINE

1989-1990 *Visiting Assistant Professor.* Lectured approximately 150 students per quarter in intermediate macroeconomics and intermediate microeconomics.

UNIVERSITY OF CALIFORNIA, IRVINE

1989 *Teaching Associate.* Lectured 266 students in introductory macroeconomics.

UNIVERSITY OF CALIFORNIA, IRVINE

1986-1988 *Teaching Assistant.* Taught discussion sections for econometrics, intermediate macroeconomics, and intermediate microeconomics.

CRAIN & THOMAS

1979-1985 *Senior Partner.* Analyzed cement industry structure and performance for a class action antitrust case. Designed campaign contributing strategies for corporate political action committees. Compiled national election statistics by district to determine the effect of congressional redistricting.

PROFESSIONAL ACTIVITIES

American Bar Association
American Economic Association
American Health Lawyers Association
Western Economic Association

PUBLICATIONS

"Geographic Market Issues in Hospital Mergers," in Douglas C. Ross and Mark J. Horoschak, *Health Care Mergers and Acquisitions Handbook,* Chicago: American Bar Association, 2003.

"Antitrust Issues Between Payers and Providers," prepared for the ABA-AHLA Health Care Antitrust Meetings, Washington DC, May 17-18, 2001. (Reprinted in two parts in *Antitrust Health Care Chronicle*, Chicago: American Bar Association, Spring 2002 and Summer 2002.)

"Efficiencies Analysis in Hospital Mergers," *Antitrust Health Care Chronicle*, Chicago: American Bar Association, Spring 1999. (Reprinted in Howard Feller, *Antitrust and Healthcare Insights into Analysis and Enforcement*, Chicago: American Bar Association, Spring 1999.)

"Hypothetical Expert Report on Damages," in Laurence H. Pretty, James L. Ewing, IV, and Tom Arnold, *Patent Litigation 1997*, Vol. 2, New York: Practising Law Institute, 1997.

"Analyzing Damages in Health Care Antitrust Cases," in Howard Feller, *Antitrust Developments in Evolving Health Care Markets*, Chicago: American Bar Association, 1996.

"The Effects of Congressional Rules About Bill Cosponsorship on Duplicate Bills: Changing Incentives for Credit Claiming," *Public Choice*, Vol. 75, No. 1, January 1993.

"Determinants of Legislative Success in House Committees," *Public Choice*, Vol. 74, No. 2, September 1992.

"A Negative Advertising Theory of Campaign Expenditures," in W. Mark Crain and Robert D. Tollison, *Predicting Politics*, Ann Arbor: University of Michigan Press, 1990.

"Do Incumbent Campaign Expenditures Matter?," *Journal of Politics*, Vol. 51, No. 4, November 1989.

SPEECHES

"What Approach Should You Use for Calculating Patent Damages: Lost Profits, Reasonable Royalties, or Both?," presented at NERA seminar series on *Intellectual Property Matters*, Newport Beach, California, February 7, 2000 and Los Angeles, California, February 8, 2000.

"Diagnosing Monopoly Pricing," presented at the NERA *Nineteenth Annual Antitrust & Trade Regulation Seminar*, Santa Fe, New Mexico, July 11, 1998.

"Direct and Cross-Examination of a Damages Expert – Demonstrations and Panel Critique," presented at the Practising Law Institute conference on *Patent Litigation 1997*, Beverly Hills, California, September 26, 1997.

"Health Care Business Problems Commonly Analyzed by Economists," presented at the Healthcare Financial Managers Association, Lone Star Chapter, *Spring Symposium*, Dallas, Texas, March 27, 1997.

"Recent Antitrust Developments in the Hospital Industry," presented at the Annual Meeting of Catholic Healthcare West Hospital CFOs, Santa Cruz, California, June 7, 1996.

CONSULTING REPORTS

Expert Report submitted on behalf of defendants in the Superior Court of Guam, Kyung Yeob Yung, et al. *v. Consolidated Transportation Services, Inc., et al.*, Civil Case No. CV2605-98, July 30, 2001.

Expert Report submitted on behalf of plaintiff in the United States District Court for the Central District of California Southern Section, *Don De Cristo Concrete Accessories, Inc. v. American Allsafe Company, Inc., et al.*, Case No. SACV00-30 AHS (EEx), May 24, 2001.

"Valuation Analysis of Putnam Hospital Center," prepared for counsel in connection with the proposed hospital merger between Vassar Brothers and Putnam in New York, March 23, 2001.

"Discussion of Patient Origin Data Analysis and HHIs Re: Proposed Lease of Sutter Merced Medical Center by Mercy Hospital and Health Services – Merced," submitted to the California Department of Justice, November 2000.

Expert Report submitted on behalf of plaintiff in the United States District Court for the District of Oregon, *Rentrak Corporation v. Susan Janae Kingston*, Case No. CV 98-1004-HA, June 13, 2000.

"Confidential Preliminary Report to Counsel Re: Proposed Merger between Baylor Health Care Systems and Texas Health Resources," submitted to the U.S. Department of Justice, the Federal Trade Commission, and the Texas Department of Justice, February 3, 1999.

"Economists' Report Submitted to the California Department of Justice Re: Proposed Acquisition of Chico Community Hospital by N. T. Enloe Memorial Hospital," prepared for N. T. Enloe Memorial Hospital, February 27, 1998.

"Expert Report on Damages," submitted on behalf of defendant in the Circuit Court for the State of Wisconsin for the County of Dane, *Uniek, Inc. v. William T. Graham v. Gregory J. Wenkman*, Case No. 94 CV 2784, June 13, 1997.

"Report on Hospital Activity in California, 1985-1996," prepared for the California Office of Statewide Health Planning and Development, January 27, 1997.

"Economists' Report Submitted to the Sacramento County Board of Supervisors Re: Proposed Designation of Mercy San Juan Hospital as a Level II Trauma Center," prepared for Mercy Healthcare Sacramento, November 7, 1996.

"Expert Report on Lost Pledges," submitted on behalf of the excess insurers in connection with the Jewish Federation Council of Greater Los Angeles matter, July 17, 1996.

"Supplemental Expert Report on Damages," submitted on behalf of plaintiff in the United States District Court for the District of Colorado, *COBE Laboratories, Inc. v. AVECOR Cardiovascular, Inc.*, Case No. 95-WY-2284-CB, May 28, 1996.

"Preliminary Expert Report on Damages," submitted on behalf of plaintiff in the United States District Court for the District of Colorado, *COBE Laboratories, Inc. v. AVECOR Cardiovascular, Inc.*, Case No. 95-WY-2284-CB, April 15, 1996.

"Economists' Report Submitted to the Montana Department of Justice Re: Proposed Great Falls Hospital Consolidation of Columbus Hospital and Montana Deaconess Medical Center," prepared for the Montana Department of Justice, March 5, 1996.

AFFIDAVITS AND DECLARATIONS

Declaration submitted in support for defendants' motion for summary judgment in the United States District Court for the Central District of California, *Bio-Medical Research Ltd, et al. v. Thane International, Inc., et al.*, Case No. CV-02-01179-R (Mcx), October 28, 2002.

Declaration submitted on behalf of plaintiff in the Superior Court of the State of California for the County of Orange, *Henry Schein, Inc. v. Western Dental Services, Inc.*, Case No. CC15106, March 14, 2002.

Affidavit submitted on behalf of defendant in the United States District Court for the District of Oregon, *Video Update, Inc. v. Rentrak Corporation*, Case No. CV98-1013-HA, July 27, 2000.

Declaration submitted in support of defendants' motion for summary judgment in the United States District Court for the Eastern District of California, *Chae Moon, M.D., et al. v. Catholic Healthcare West, et al.*, Case No. CIV-S 97-2359-DFL DAD, July 26, 1999.

Affidavit submitted on behalf of defendant in the Superior Court of the State of North Carolina for the County of Mecklenburg, *Novant Health, Inc. et al. v. Aetna U.S. Healthcare of North Carolina, Inc.*, Case No. 98-CVS-12661, October 30, 1998.

Declaration submitted in support of defendants' motions for summary adjudication in the Superior Court of the State of California for the County of Los Angeles, *Arun K. Mittal, M.D., et al. v. BayShore Medical Group, et al.*, Case No. BC 172899, April 9, 1998.

Affidavit submitted in support of defendants' motion for summary judgment in the United States District Court for the Eastern District of California, *Four A Farms, et al. v. California-Oregon Seed, Inc., et al.*, Case No. CIV-S-94-978 EJG PAN, October 20, 1995.

Declaration submitted in opposition to defendants' motion for summary adjudication in the United States District Court for the Central District of California, *BMMG, Inc., et al. v. American Telecast Corporation, et al.*, Case No. CV 92 3308 HLH, April 19, 1993.

Declaration submitted in support of defendants' motion for summary judgment in the Superior Court of the State of California for the County of Orange, *Ivar Roth, et al. v. Frank Rhodes, et al.*, Case No. 625223, September 28, 1992.

PRESENTATIONS

Part of presentation team on behalf of Baylor Health Care Systems and Texas Health Resources at a meeting with the Texas Department of Justice in connection with the proposed merger between the two health care systems, June 16, 1999.

Part of presentation team on behalf of N. T. Enloe Memorial Hospital at a meeting with the California Department of Justice in connection with the proposed acquisition of Chico Community Hospital by N. T. Enloe Memorial Hospital, March 20, 1998.

Part of the presentation team on behalf of Mercy Healthcare Sacramento at a meeting of the Sacramento County Board of Supervisors in connection with the proposed designation of Mercy San Juan Hospital as a Level II Trauma Center, January 14, 1997.

Part of the presentation team on behalf of the excess insurers at a mediation in connection with the Jewish Federation Council of Greater Los Angeles matter, January 7, 1997.

DEPOSITION TESTIMONY

Testimony presented on behalf of defendant in the Superior Court of the State of California for the County of Los Angeles, *Universal Bank v. Moss Adams, LLP, et al.*, Case No. BC 263 709, June 11, 2003.

Testimony presented on behalf of plaintiff in the Superior Court of the State of California for the County of Orange, *Henry Schein, Inc. v. Western Dental Services, Inc.*, Case No. CC15106, February 14, 2002.

Testimony presented on behalf of plaintiff in the United States District Court for the Central District of California in the Southern Section, *Don De Cristo Concrete Accessories, Inc. v. American Allsafe Company, Inc., et al.*, Case No. SACV00-30 AHS (EEx), July 23, 2001.

Testimony presented on behalf of defendant in the Superior Court of the State of California for the County of Los Angeles, *MetalMart, Inc. v. Samuel Allen, et al.*, Case No. BC200847, May 25, 2001.

Testimony presented on behalf of plaintiff in the Superior Court of the State of California for the County of Orange, *Sidney Born v. Y. Michael Kim, et al.*, Case No. 818058, April 30, 2001.

Testimony presented on behalf of defendant in the Circuit Court for the State of Wisconsin for the County of Dane, *Uniek, Inc. v. William T. Graham v. Gregory J. Wenkman*, Case No. 94 CV 2784, June 19, 1997.

ARBITRATION TESTIMONY

Testimony presented on behalf of counterclaimant at the American Arbitration Association in the State of California, *Interstate Rehab, Inc. v. Target Healthcare, Inc.*, Case No. 72 193 255 00, October 19-20, 2000.

TRIAL TESTIMONY

Testimony presented on behalf of defendant in the Superior Court of the State of California for the County of Los Angeles, *MetalMart, Inc. v. Samuel Allen, et al.*, Case No. BC200847, June 11, 2001.

Testimony presented on behalf of defendant in the Superior Court of the State of California for the County of Los Angeles, *Helen D. Zweck v. GTE California, Inc.*, Case No. BC 142687, June 3 and 5, 1997.

June 2003

List of Materials Relied Upon
Re: Proposed Conversion of Premera Blue Cross

Description	Response to Request	Bates Numbers
Expert Reports		
Cantilo & Bennett, Report to Insurance Commissioner. [Draft and Final Report.]	NA	NA
Preliminary Report of Keith Leffler, Ph.D., "Premera Conversion Antitrust Review. "	NA	NA
PricewaterhouseCoopers ("PwC"), Economic Impact Analysis of the Proposed Conversion dated October 3, 2003.	NA	NA
PwC, Accounting & Tax Evaluation of the Proposed Conversion of Premera Blue Cross of Washington. [Draft and Final Report.]	NA	NA
PwC, Economic Impact Analysis of the Proposed Conversion dated October 27, 2003. [Final Report.]	NA	NA
PwC, Executive Compensation Review: Competitiveness and Reasonableness of Premera Practices. [Draft and Final Report.]	NA	NA
PwC, Report to the Washington State, Office of the Insurance Commissioner on Tax Matters in Connection with the Proposed Conversion of Premera. [Draft and Final Report.]	NA	NA
Report of Keith Leffler, Ph.D.. "Premera Conversion Antitrust Review," October 27, 2003. [Final Report.]	NA	NA
The Blackstone Group, Report on Valuation and Fairness of the Proposed Conversion. [Draft and Final Report.]	NA	NA
Premera Documents		
Background Material in Premera Binder	NA	NA
Tab A: Overview of New Premera Operations, Exhibit E-7 (unredacted).	NA	NA
Tab B: M&R Actuarial Projections.	41	0010284-92
Tab C: 2002 Premium, Claims and Admin Adjustments.	70	0016041-3
Tab D: Additional E-7 Back-up Material.	70	0016044-95
Tab E: Response to Request #76.	76	0016096-7
Tab F: 1997 - 2001 Premium History.	84	0016586-8
Tab G: 1997 - 2002 Underwriting Reject Rate.	85	0016107-8
Tab H: Line of Business Financials.	86	0016109
Tab I: Loss and Experience Ratios.	87	0016110
Tab J: Acquisition Agreements.	WA127	0009927-10032
Tab K: 1997 - 2002 Financial and Income Statement.	26	0015960-6037
Tab L: Market Shares (WA, AK, OR).	90	0011974-2001
Binder re: Premera Reorganization Process	NA	NA
Tab 1: Introduction to Premera Slide Presentation.	NA	NA
Tab 2: Premera Reorganization Presentation to Washington OIC and Alaska Division of Insurance, June 6, 2002.	NA	NA
Tab 3: Letters from Premera to Christine Gregoire, Washington State Attorney General re: Follow-up to January 31, 2002 meeting re: House Bill 2360, and Attorney General of Washington Memo re: Respective Responsibilities of the OIC and Attorney General in the Review of Premera's Application.	NA	NA
Tab 4: Holding Company Acts for Washington and Alaska.	NA	NA
Tab 5: Letter from John Ellis, Special Assistant Attorney General, to Premera re: Conversion Application, December 4, 2002.	NA	NA
Administrative Costs by Line of Business, September 2002.	842	0029825-6
Analysis of Experienced Allowable Reimbursement Level on Professional Claims ["8-14-03 Professional Experience CF.doc"].	NA	NA

List of Materials Relied Upon
Re: Proposed Conversion of Premera Blue Cross

Description	Response to Request	Bates Numbers
Analysis of market share for various categories by product line and geographic region.	WA-90	0011974-2010
Arizona August Financial Report.	NA	NA
Arizona Budget/Actual Variance Report ["Arizona AUGUST Financial Report.xls"].	NA	NA
Attachment C Quality Incentive Agreement Details of Attribution Methodology ["Att C QI Inc Details of Attribution algorithm.2003.doc"].	NA	NA
Attachment D Quality Incentive Agreement Details of Attribution Methodology ["Details of attribution algorithm.doc"].	NA	NA
Audrey Questions ["10-9-03 Audrey Questions.doc"].	NA	NA
Base Rate Calculation Effective 11/1/2000 - 10/31/2001 ["10-11-03 PBC-Sm-AreaFac.xls"].	NA	NA
BCWA 1997 Healthy Options ["1997 BCWA HO.ppt"].	NA	NA
Broker spreadsheets re: proposal or renewable summary.	NA	NA
Center for Health Statistics Hospital Data ["Hospital financials website.pdf"].	NA	NA
Counties where Premera offered Healthy Options, Medicare + Choice, Basic Health, Public Employees Benefits Board, Federal Employees Health Benefits (FEHB) Product, or Washington Education Association Plan or Product ["10-28-03 Access Issue - Premera Programs.xls"].	NA	NA
Current Premera Fee Schedule Broken Down by Geographic Region, Effective September 1, 2002 through August 31, 2003.	NA	NA
Data requests for PBC Consultants ["9-5-03 PBC consultant req [re rvcm oic.xls].xls"].	NA	NA
Definitions of Geographic Areas ["7-2-03 Zip table 9262001.xls"].	NA	NA
Details on Minority Interest or Investments Included on Premera's Balance Sheet.	WA 29	0007284
Dimensions Rating Areas ["Dimensions Rating Areas.xls"].	NA	NA
Dimesions Actual Groups & Members, Care Facilitation Programs and other documents.	E509	0033956-63
Dimensions New Sales Tracking Tool for 2003.	NA	NA
E WA - Small Non-Standard Providers ["EWA SM_NS_providers.xls"].	NA	NA
Eastern Washington Market Share ["Estimated EWA 2002 Market Share.xls"].	NA	NA
Estimate of Premera ASO Market Share for WA and AK, 2001.	843	0032196-7, 0032495-7
Estimated Western Washington Market Share ["Estimated March 2002 WWA Market Share Comparison.xls"].	NA	NA
Explanation of Measures ["TEC Explanation of Measures.doc"].	NA	NA
February 11, 2003 Letter from Premera to Christine Gregoire, Washington State Attorney General.	NA	NA

List of Materials Relied Upon
Re: Proposed Conversion of Premera Blue Cross

Description	Response to Request	Bates Numbers
Fee Schedule Historical Impact for Premera Blue Cross ["WA Physician Fee Schedule History.xls"].	NA	NA
FEP Enrollment for WA and AK, December 1997 - September 2002.	Z833	0022152-3
Form B filings submitted to the OIC, 1997 - 2002.	NA	NA
Group Disenrollment Research Summary, January - December 2001.	NA	NA
Group Medical Disenrollment Research Summary, July 2002.	NA	NA
Historical Small Group Area Factors for WA and AK, 1998 - 2002.	841	0024813-29
HSR Filing in Connection with the 1994 Affiliation between Blue Cross of Washington and Alaska and Medical Service Corporation, 1994.	NA	NA
Information re: Premera's Dimensions plans including financial performance, competitive analyses and correspondence.	E446, E447, E449	0030597-1169
IT Security Procedures for Remote Access.	831	0021778-811
List Of Physician Agreements That Provides For Above-Standard Fees And That Have 20 Or More Physicians.	E545	0035799-803
Listing of Providers Included in Networks for Each Product.	B156	0019882 and CD
Medical Options ["Lindr Goets pacific life.doc"].	NA	NA
Memo re: Response to 849 ["Conversion_Response_20030523.doc"].	849	NA
Monthly Win/Loss Analysis, Q1 2001 through Q3 2002.	NA	NA
PBC Regence Comparison reflected as a % of Medicare ["PBC Regence historical comparison.xls"].	NA	NA
PBC Regence Comparison reflected as a % of Medicare Washington Composite ["PBC Regence Comparison reflected as % of Medicare.xls"].	NA	NA
Pharmacy Incentive Agreement Between Premera Blue Cross AND Physicians Clinic of Spokane ["PCS_PIP_Agreement_FINAL.doc"].	NA	NA
Pharmacy Incentive Plan Medical Group Index and Payout Amounts by Quarter ["PIP_QIP_Performance.xls"].	NA	NA
Physician Counts ["E516 - 051203.xls"].	E516	NA
Physician Fee Schedule Data ["2002 FS Data.xls"].	NA	NA
Physicians' Clinc of Spokane 2nd Qtr 2003 Estimate of Rx Incentive Program Performance Data excludes Medicare, Medicaid, and ASO Groups Claims paid from 04/01/2003 through 06/30/2003 ["PCS_PIP_Q203.xls"].	NA	NA
Premera Blue Cross 1998 Healthy Options and Basic Health ["1998 HO BHP.ppt"].	NA	NA
Premera Blue Cross 1999 Healthy Options and Basic Health ["1999 HO BHP.ppt"].	NA	NA
Premera Blue Cross 2000 Healthy Options and Basic Health ["2000 HO BHP.ppt"].	NA	NA
Premera Blue Cross 2001 Healthy Options and Basic Health ["2001 HO BHP.ppt"].	NA	NA

List of Materials Relied Upon
Re: Proposed Conversion of Premera Blue Cross

Description	Response to Request	Bates Numbers
Premera Blue Cross 2002 Healthy Options and Basic Health ["2002 HO BHP.ppt"].	NA	NA
Premera Blue Cross 2003 Healthy Options and Basic Health ["2003 HO BHP.ppt"].	NA	NA
Premera Blue Cross Pharmacy Incentive Pilot Program Letter of Agreement ["Pharmacy Incentive LoA 12.17.02.doc"].	NA	NA
Premera Blue Cross Top 25 Procedure Code Summary - Allowed Amounts Incurred 7/2001 - 6/2002, Paid Through 11/2002 ["Top 25 by WA County.xls"].	NA	NA
Premera Board and Committee Minutes Where the Dimensions Plans Were Discussed.	E540	0025945-83
Premera Business Decisions Report, 2001 ["Master 2001_12_121101M.Xls"].	E563	NA
Premera Business Decisions Report, 2002 ["Master 2002_12_122402M.Xls"].	E563	NA
Premera Business Decisions Report, 2003 ["Master 2003_06_062503M.Xls"].	E563	NA
Premera Business Decisions Report Year-To-Date Thru 9/2003 ["BDR Summary Thru 9-2003.Xls"].	NA	NA
Premera Claims, Premiums and Enrollment Data ["432_Revision_A.xls"].	432	NA
Premera Data regarding Healthy Options and Basic Health Plan.	NA	NA
Premera Data regarding Hospitals ["7-21-03 PBC Hospitals WAONLY.xls"].	NA	NA
Premera Dimensions Rate Filing Summaries.	869-870	0032324-13779
PBC Facility Claims Experience by Rural and Urban Designation, 1st Half of 2002 Dates of Service Paid through August ["summary to brian~ST.xls"].	NA	NA
Premera document titled "Premera Professional Provider Reimbursement, Claims Incurred 9/2002 - 6/2003, Paid Through 6/2003, By State, By County, By Specialty" for Standard and Non Standard Fee Schedules, received August 14, 2003.	NA	NA
Premera document titled "Premera Combined Financial Projections and Assumptions."	NA	0016047 - 053
Premera Enrollees, Total Premiums Paid, Total Claims By County And By Line of Business.	E432A	0032344-6 and CD
Premera Exhibit E7 to the Form A Filing, October 25, 2002.	NA	NA
Premera file "PBC Hospitals WAOnly.xls."	NA	NA
Premera financial data ["rvcm oic (WA26).xls"].	WA26	NA
Premera Incentive Program - Attachment A, Rockwood Clinic , P.S. ["RWC Incentive program 3.5.03.xls"].	NA	NA
Premera Incentive Programs - Attachment A, Wenatchee Valley Clinic ["Att A WVC Incentive Program 2003.xls"].	NA	NA
Premera Lifewise Disenrollment Survey, A Premera Market Research Summary, July 3, 2002 ["Premera Lifewise Disenrollment Survey-Summary.Doc"].	NA	NA
Premera Lifewise Member Disenrollment Survey ["Premera Lifewise Member Disenrollment 4-15-02.Doc"].	NA	NA

List of Materials Relied Upon
Re: Proposed Conversion of Premera Blue Cross

Description	Response to Request	Bates Numbers
Premera Listing of Providers in Networks for Each Product ["Supplemental Information Request_Item B156.mdb"].	B156	NA
Premera Market Share Analysis Based on WA OIC Annual Statements as of December 31, 1999 ["WAMkt1999EOY.xls"].	NA	NA
Premera Market Strategy ["WA 2002 Membership Analysis.xls"].	NA	NA
Premera Market Strategy Washington Annual Membership Analysis June 30, 2001 to June 30, 2002 ["WA June 2001 vs June 2002 Analysis.doc"].	NA	NA
Premera Market Strategy Washington Annual Membership Analysis March 31, 2001 to March 31, 2002 ["WA March 2001vs March 2002 Analysis.doc"].	NA	NA
Premera Market Strategy Washington Annual Membership Analysis September 30, 2001 to September 30, 2002 ["WA Sept 2001 vs Sept 2002 Analysis.doc"].	NA	NA
Premera Marketing Strategy Washington Annual Membership Analysis December 31, 2000 to December 31, 2001 ["WA2001vs2000Analysis.doc"].	NA	NA
Premera Members by Line of Business and County, June 1998.	E434A	0032322 and CD
Premera Membership in Eastern Washington, June 1998 ["June 1998 Membership Rev A (E434A).xls"].	E432A	NA
Premera Monthly Activity Report for New and Cancelled Groups ["Monthly Activity Report for New Cancelled Groups.xls"].	NA	NA
Premera Number and Type of Provider Contracts in Each Network By County or Relevant Geographic Area ["Supplemental Information Request_Item D302.mdb"].	D302	NA
Premera's "Performance Quarterly Reports to Board of Directors" for the first two quarters of 2003.	NA	NA
Premera Professional Provider Reimbursement By State, By County, By Specialty Claims Incurred 9/2002 - 6/2003, Paid Through 6/2003 ["8-14-03 Final CF Analysis Summaries.xls"].	NA	NA
Premera Proposal Activity ["7-21-03 51-99 Proposal Activity.xls"].	NA	NA
Premera Quality & Incentive Programs ["who's who.ppt"].	NA	NA
Premera Response to 849.	849	NA
Premera Response to OIC Request # E432A.	E432A	NA
Premera Response to OIC Request # E516.	E516	NA
Premera Revised Form B Data, 2002.		
Premera Small Group Rate Filing Loss Ratio by Delivery Type, By Area, and Premera Small Group Contribution by E WA and W WA.	E539 & E540	0025681-5
Premera Top 25 Codes by Geographic Region - Allowed Dollars, Incurred March 2001 to February 2002.	NA	NA
Premera Top 25 Procedure Code Summary by County - Allowed Amount, Incurred July 2001 to June 2002.	NA	NA

List of Materials Relied Upon
Re: Proposed Conversion of Premera Blue Cross

Description	Response to Request	Bates Numbers
Premera Top 25 Procedure Code Summary by County - Utilization, Incurred July 2001 to June 2002.	NA	NA
Premera's Estimate of Eastern WA market share.	NA	NA
Presentations to Premera Board of Directors and Premera Management re: B&ST/Dimensions Project, 2002 - 2002.	E448	0023041-586, 0024687-812, 0029512-785
Private Insurers' Annual Statements Filed with the OIC for the Year Ending December 31, 1997 - 2000.	NA	NA
Project Board Planning ["Base Case Model.xls"].	NA	NA
Provider Specialty Logic ["Provider Specialty Codes Used For 432 Data.Xls"].	432	NA
Puget Sounds Business Journal - Western Washington enrollment numbers, May 1999 to July 2002.	NA	NA
Quality Incentive Agreement Between Premera Blue Cross And Rockwood Clinic, P.S. ["RWC QI Agreement 02.26.03.Doc"].	NA	NA
Quality Incentive Agreement Between Premera Blue Cross And The Everett Clinic ["QI Agreement 10.29.2002.Doc"].	NA	NA
Quality Incentive Agreement Between Premera Blue Cross And Wenatchee Valley Clinic ["QI Agreement 01.01.03.Final.Doc"].	NA	NA
Question re: E516 - Why are Counties in Oregon and Idaho Included in Reponse to E516?	E546	0035804
Rate Filings for Selected Plans.	WA65	0030416, 0014238-316, 0032758-3351, 0033352-808
Reponse to Question re: file Z805A - allocation of administrative costs by line of business.	842b	0031636-8
Sacred Heart-Kittitas Valley, Outpatient Overview ["Sacred Heart-Kittitas Valley Comparison.xls"].	NA	NA
Small Group Rate Filing Loss Ratio by Delivery Type By Area, Small Group Contribution by Eastern WA and Western WA ["Attachments for Auditors_20030523.xls"].	NA	NA
Small Rate Group Filing.	E542 & E544	0035876-8
Small Rate Group Filing Effective 6/1/2003.	E509	0035134-249
Spokane Journal of Business Book of Lists - Eastern Washington enrollment numbers, December 1999 to October 2002.	NA	NA
Standard Fee Schedule, 2002 ["Premera Fee Schedule Compare.xls"].	NA	NA
Summary of Premera Provider Contracts by Network and County.	D302	0018652-3, 0029259-60, and CD
The Effect of HMO Conversion to For-Profit Status ["EffectofHMOConversions-Final2-4-03.pdf"].	NA	NA
The Everett Clinic 2003 Incentive Program (Attachment B) ["TEC Incentive Program 10.28.02 .xls"].	NA	NA

List of Materials Relied Upon
Re: Proposed Conversion of Premera Blue Cross

Description	Response to Request	Bates Numbers
Top 25 Codes by Allowed Dollars Claims Incurred 3/2001 - 2/2002 Paid Through 6/2002 ["Top 25 Codes by Allowed per Region.xls"].	NA	NA
Total Premera Membership [mbrs by region 200112 - 200306.xls]	NA	NA
Transcript of the Public Meeting in the Matter of the Proposed Conversion of Premera Blue Cross to a For-Profit Corporation in Richland, WA, October 8, 2002.	NA	NA
Transcript of the Public Meeting in the Matter of the Proposed Conversion of Premera Blue Cross to a For-Profit Corporation in Seattle, WA, September 30, 2002.	NA	NA
Transcript of the Public Meeting in the Matter of the Proposed Conversion of Premera Blue Cross to a For-Profit Corporation in Spokane, WA, October 2, 2002.	NA	NA
Transcript of the Public Meeting in the Matter of the Proposed Conversion of Premera Blue Cross to a For-Profit Corporation in Vancouver, WA, October 15, 2002.	NA	NA
U.S. Census Washington State Age 65+ Population, 2000 ["WA65GenderCounty2000Census.xls"].	NA	NA
U.S. Census, Population Data by County for Washington, 2000 ["WAAgeGenderCounty2000Census.csv"].	NA	NA
U.S. Census, Population Data, 2000. ["WAPopSexAgeCensus2000.xls"].	NA	NA
Underwriting Peer Review / Authority Matrix.	E526	0035279-80
US Department of Commerce, "Profile of General Demographic Characteristics," 2000.	NA	NA
Washington 2001 Membership Analysis ["WA 2001 Membership Analysis.xls"].	NA	NA
Washington Market Share Healthy Options ["WA Healthy Options 2000 vs 2001 Market share.ppt"].	NA	NA
Washington Market Share Individual (Includes BHP) ["WA Individual 2000 vs 2001 Market Share.ppt"].	NA	NA
Washington Market Share Medicare Supplement ["WA Medicare Sup 2000 vs 2001 Market Share.ppt"].	NA	NA
Washington Market Share ["WA 2000 vs WA 2001 Market Share.ppt"].	NA	NA
Washington Market Share ["WA June 2001 vs June 2002.ppt"].	NA	NA
Washington Market Share ["WA March 2001 vs March 2002.ppt"].	NA	NA
Washington Market Share ["WA Market Share EOY 1999.ppt"].	NA	NA
Washington Market Share ["WA Market Share EOY 2000.ppt"].	NA	NA
Washington Market Share ["WA Sept 2001 vs Sept 2002.ppt"].	NA	NA
Washington Market Share based on WA OIC Financials, 1998.	NA	NA
Washington Par/PPO (Bluechip) Professional Provider Summary Claims Incurred 7/2000 - 6/2001, Paid Through 9/2001 ["Len 2003_03_03.xls"].	NA	NA
Washington Professional Fee Schedule Update, 2002 ["DSC Presentation 020502 Draft 4.ppt"].	NA	NA

List of Materials Relied Upon
Re: Proposed Conversion of Premera Blue Cross

Description	Response to Request	Bates Numbers
Win Loss Data ["Jeff's Info.xls"].	NA	NA
Won-Lost Data, 2002 ["won-lost 2002.xls"].	NA	NA
Regulations		
Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Sections 2712 and 2742.	NA	NA
RCW 48.31C.030 (5) (a) (ii).	NA	NA
RCW 48.44.017(3)(d).	NA	NA
RCW 48.44.020(3).	NA	NA
RCW 48.44.024.	NA	NA
RCW 48.44.037.	NA	NA
RCW 70.44.450.	NA	NA
RWC 70.44.450 - Rural Public Hospital Districts -- Cooperative Agreements and Contacts.	NA	NA
WAC 284.43.200 - Network Adequacy.	NA	NA
Other Documents		
Journal Articles and Books		
Associated Press Newswire, "Carriers Again Offer Individual Policies," December 3, 2000.	NA	NA
Carlton, D. and J. Perloff, Modern Industrial Organization 3rd ed. (New York: Addison-Wesley, 2000).	NA	NA
Conover, C. and M. Hall, "For-Profit Conversion of the Blue Cross and Blue Shield of North Carolina: Assessment of the Potential Impact on Accessibility and Affordability of Health Care," A Report to the North Carolina Department of Insurance.	NA	NA
Conover, C. and M. Hall, "Summary of Key Informant Interviews,". Appendix B to their report prepared for the North Carolina Insurance Department, October 11, 2002.	NA	NA
Dranove, D. The Economic Evolution of American Health Care (New Jersey, Princeton University Press, 2000).	NA	NA
Feldman, R. and D. Wholey, "Do HMOs Have Monopsony Power," International Journal of Health Care Finance and Economics I (2001).	NA	NA
Feldman, R. and D. Wholey, and R. Town, "The Effect of HMO Conversions to For-Profit Status," Final Report, February 3, 2003.	NA	NA
Hadley, J. and J. Mitchell, "HMO Penetration and Physicians' Earnings," Medical Care Vol. 37 (1999), pp. 1116-1127.	NA	NA
Lynk, W. "Property Rights and the Presumptions of Merger Analysis," The Antitrust Bulletin (Summer 1994), pp. 363- 383.	NA	NA
McCarthy, T. and S. Thomas, "Antitrust Issues Between Payers and Providers," prepared for the ABA-AHLA Health Care Antitrust Meetings, Washington DC, May 17-18, 2001.	NA	NA

List of Materials Relied Upon
Re: Proposed Conversion of Premera Blue Cross

Description	Response to Request	Bates Numbers
McCarthy, T. and S. Thomas, "Geographic Market Issues in Hospital Mergers," in Douglas C. Ross and Mark J. Horoschak, Health Care Mergers and Acquisitions Handbook, Chicago: American Bar Association, 2003.	NA	NA
Melnick, G., J. Zwanziger, A Bamezai, and R. Pattison, "The Effects of Market Structure and Bargaining Position on Hospital Prices," Journal of Health Economics 11 (1992), pp. 217-233.	NA	NA
Melnick, G., J. Zwanziger, and A. Verity-Guerra, "The Growth and Effects of Hospital Selective Contracting," Health Care Management Review (Summer 1989), pp. 57-66.	NA	NA
National Center for Health Statistics, CDC, "Vital and Health Statistics, Health Service Areas for the United States, Series 2: Data Evaluation and Methods Research, No. 112," November 1991.	NA	NA
Pauly, M. "Managed Care, Market Power, and Monopsony," Health Services Research 33 (December 1998), pp. 1439-1460.	NA	NA
Rubinfield, D. , "Econometrics in the Courtroom," Columbia Law Review 85 (1985), pp. 1048-1097.	NA	NA
Simpson, J. and Shin, R., "Do Nonprofit Hospitals Exercise Market Power?" International Journal of the Economics of Business, Vol. 5, No. 2, 1998, pp. 141-157.	NA	NA
Other Information		
AMA Physician Count, 1994 - 2002.	NA	NA
Business Wire, "QualMed of Washington Announces Its New Name - Molina Healthcare of Washington," July 17, 2000.	NA	NA
Business Wire, "Success of USelect Plan in Spokane, Wash., Leads Vivius and Health Net to Launch USelect in 14 Additional U.S. Markets," May 27, 2003.	NA	NA
CMS website, Medicare and Medicaid Managed Care data.	NA	NA
First Choice Health Network Annual Report, 2002.	NA	NA
'Health Insurer Annual Statements, December 31, 2002, http://www.insurance.wa.gov/special/coverwashington/answers/market_share_analysis.doc.	NA	NA
Interstudy HMO and PPO Enrollment Data.	NA	NA
OB GYN News, "Access, Care Unharmed by Blue Cross Conversions: Uninsured, Rates Have Not Risen," August 15, 2003.	NA	NA
PR Newswire, "New Health Insurance Carrier to Receive Certificate of Authority From Washington State,"August 15, 1997.	NA	NA
Puget Sound Business Journal, "NorthwestOne pushes across the Cascades," , July 5, 1999, [http://seattle.bizjournals.com/seattle/stories/1999/07/05/newscolumn3.html].	NA	NA
U.S. Census Bureau, "Table HI-4, Health Insurance Coverage Status and Type of Coverage by State, All People: 1987 to 2002."	NA	NA
U.S. Census Bureau, "Washington County Population Estimates: April 1, 2000 to July 1, 2002."	NA	NA

List of Materials Relied Upon
Re: Proposed Conversion of Premera Blue Cross

Description	Response to Request	Bates Numbers
UnitedHealth Group, "United HealthCare Completes MetraHealth Acquisition," News Release, October 3, 1995.	NA	NA
Washington Insurers' websites.	NA	NA
Washington OIC website, "Let's Get Washington Covered" [www.insurance.wa.gov/special/coverwashington/answers/rateincreases.asp].	NA	NA
Washington State Hospital Association, "Profile of Washington State Health Plans," Fall 1998 to 2003 Reports.	NA	NA
Washington State Office of the Insurance Commissioner website [http://www.insurance.wa.gov/].	NA	NA
Charles J. Singer & Co., "Managed Care Market Overview: Seattle-Tacoma-Bremerton, WA," February 1995, October 1995, and May 1996.	NA	NA
CJ Singer, "Managed Care Market Overview: Seattle-Tacoma-Bremerton, WA," September 1997.	NA	NA
Gartner Analytics, "Managed Care Market Overview: Seattle-Tacoma-Bremerton, WA," March 1998.	NA	NA
Gartner Group, "Healthcare Market Overview: Seattle-Tacoma-Bremerton, WA," October 1998.	NA	NA
Gartner Group, "Seattle, Washington, Healthcare Market Overview: December 1999."	NA	NA
HealthLeaders, "Market Overview, Seattle, Washington, Healthcare Market Overview," April 2002 and February 2003.	NA	NA
Blue Cross Blue Shield Association, "Guidelines to Administer Membership Standards Applicable to Regular Members," September 18, 2003.	NA	NA
National Center for Health Statistics, CDC, "Vital and Health Statistics, Health Service Areas for the United States, Series 2: Data Evaluation and Methods Research, No. 112," November 1991.	NA	NA

Appendix B – Substantive Information

Table B-1

Market Shares for Washington Health Insurers
Based on Premiums
1997 - 2002

Insurer	1997	1998	1999	2000	2001	2002
Group Health	20.6 %	20.2 %	19.7 %	20.9 %	25.6 %	27.1 %
Premera	24.1 [1]	23.8	24.8	25.8	27.1	26.3
Regence	24.2	23.6	26.9	25.2 [2]	22.8	22.5
PacifiCare	7.5	7.7	7.6	8.1	8.0	7.6
Community Health	1.5	1.9	2.6	3.9	4.6	4.6
Kaiser	3.2	3.2	3.2	3.2	3.4	3.7
Molina	-	-	-	1.7	3.1	3.6
KPS	2.0	2.0	1.9	1.2	1.3	1.5
Aetna[3]	1.2	1.5	3.7	3.1	2.1	1.5
First Choice	0.5	0.9	1.4	2.0	1.0	0.6
Providence	4.4	5.6	0.5	0.6	-0.1	0.1
One Health	-	0.0	0.2	0.3	0.1	0.1
United HealthCare	-	0.0	0.2	0.7	0.0	0.0
Others	10.8	9.6	7.2	3.3	0.9	1.0
Total	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**

Notes: Figures reflect all fully-insured business in the state of Washington except for the dental and vision business.

Figures do not include disability insurers that offer health insurance. In particular, premiums for CIGNA were not available since CIGNA offers its health product through its subsidiary, Connecticut General Life.

"na" indicates that the health plan existed but information was not available for that year.

"-" indicates that the health plan was not available in that year.

[1] 1997 figure for Premera is adjusted to include premiums for MSC, which merged into Premera in 1998.

[2] 2000 figure for Regence does not include data for Northwest WA Medical Bureau, which Regence acquired in Novmber 2000.

[3] Information for Aetna U.S. Healthcare of WA (PPO) was not available for 1998.

Sources: Washington State Hospital Association, "Profile of Washington State Health Plans," Fall 1998 to 2003 Reports.

Table B-2

Summary of Results for Premium Regressions
Sensitivity Test

Dependent Variable: Premiums per Member

Coefficients / (t-statistics)

Explanatory Variable	Parent Regressions		Plan Regressions	
	Year Dummies	Time Trend	Year Dummies	Time Trend
Constant	PROPRIETARY MATERIAL REDACTED			
Medical Expenses per Member				
HMO Membership Percent				
Medicare Managed Care Membership Percent				
Medicaid Managed Care Membership Percent				
Medicare Supplement Membership Percent				
Premera Dummy Variable				
R-Square				
F-Statistic				
Observations				

* Significant at 5 percent level.
** Significant at 1 percent level.

Note: Results are based on excluding 1997 - 1999 data since the Medicare Supplement information is not available for that period.

Table B-3

Premera's Estimated Share of the Provider Purchases
Western Washington
2001 - 2002

		2001	2002
(1)	Total Population	4,672,933	4,732,152
(2)	Uninsured Population	614,652	670,276
(3)	Covered by Military	217,492	237,357
(4)	Insured Population	3,840,788	3,824,519
(5)	Premera's Enrollment	473,373	449,424
(6)	Premera's Estimated Share	12.3%	11.8%

Notes: Premera's enrollment figures exclude Medicare Supplement and self-insured members.
Line (4) = Line (1) - Line (2) - Line (3)
Line (6) = Line (5) / Line (4)

Sources: Line (1): U.S. Census Bureau, "Washington County Population Estimates: April 1, 2000 to July 1, 2002."
Lines (2) & (3): U.S. Census Bureau, "Table HI-4, Health Insurance Coverage Status and Type of Coverage by State, All People: 1987 to 2002."
Line (5): 2001 and revised 2002 Premera Form B filings.

Premera Revised Form B Data for 2002

County	Area	Blue Cross Blue Shield Mark	Orig 2002 Data	Revised 2002 Data
Adams	Eastern WA	Yes	4,787	4,488
Asotin	Eastern WA	No	1,408	1,707
Benton	Eastern WA	Yes	32,292	32,292
Chelan	Eastern WA	Yes	21,537	21,537
Clallam	Western WA	No	6,921	6,920
Clark	Western WA	No	10,642	10,631
Columbia	Eastern WA	No	510	501
Cowlitz	Western WA	No	5,040	4,925
Douglas	Eastern WA	Yes	5,168	5,016
Ferry	Eastern WA	Yes	1,486	1,494
Franklin	Eastern WA	Yes	9,426	9,541
Garfield	Eastern WA	No	585	578
Grant	Eastern WA	Yes	20,520	20,684
Grays Harbor	Western WA	No	8,922	8,883
Island	Western WA	No	6,249	6,250
Jefferson	Western WA	No	2,010	1,902
King	Western WA	No	214,988	214,926
Kitsap	Western WA	No	10,705	10,548
Kittitas	Eastern WA	Yes	8,579	8,734
Klickitat	Eastern WA	No	1,948	1,947
Lewis	Western WA	No	8,089	7,043
Lincoln	Eastern WA	Yes	4,141	4,236
Mason	Western WA	No	4,052	3,176
Okanogan	Eastern WA	Yes	7,422	8,348
Pacific	Western WA	No	4,269	4,010
Pend Oreille	Eastern WA	Yes	2,642	2,839
Pierce	Western WA	No	59,476	59,485
San Juan	Western WA	No	1,058	1,010
Skagit	Western WA	No	8,806	8,830
Skamania	Western WA	No	21,781	302
Snohomish	Western WA	No	97,028	63,297
Spokane	Eastern WA	Yes	40,712	93,313
Stevens	Eastern WA	Yes	5,180	8,446
Thurston	Western WA	No	21,074	20,422
Wahkiakum	Western WA	No	2,081	318
Walla Walla	Eastern WA	No	7,744	6,961
Whatcom	Western WA	No	18,522	16,546
Whitman	Eastern WA	Yes	5,437	8,990
Yakima	Eastern WA	No	25,318	27,479
Total			**718,555**	**718,555**

Note: The Form B data used to identify Premera's enrollment for 2002 has been revised from the data originally submitted to the state. During our analysis, we noted that enrollment data for some counties appear to be inaccurate. (Dr. Leffler noted similar inaccuracies in footnote 69 of his report.) Upon review with Premera, we have determined that coding and clerical errors were made on the data in the original filing. The Premera Form B data that we use in our report is the preliminary revision to the data that Premera will refile once Premera has reconfirmed the accuracy of these revisions.

Source: Premera Blue Cross.

Premera's Estimated Share of the Total Purchases of Provider Services
By Health Service Area (HSA)
2001 - 2002

HSA		2001 Total Population	2001 Uninsured Population	2001 Covered by Military	2001 Insured Population	2001 Premera's Enrollment	2001 Premera's Estimated Share	2002 Total Population	2002 Uninsured Population	2002 Covered by Military	2002 Insured Population	2002 Premera's Enrollment	2002 Premera's Estimated Share
					(1) - [(2) + (3)]		(5) / (4)				(7) - [(8) + (9)]		(11) / (10)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Eastern Washington													
694	Asotin-Garfield Counties	22,796	2,998	1,061	18,737	2,403	12.8 %	22,780	3,227	1,143	18,411	2,285	12.4 %
698	Spokane, WA	492,806	64,821	22,937	405,048	109,886	27.1	497,434	70,458	24,950	402,025	110,328	27.4
702	Kennewick-Richland-Pasco, WA	196,659	25,867	9,153	161,638	43,805	27.1	203,111	28,769	10,188	164,154	41,833	25.5
717	Columbia-Walla Walla Counties	59,425	7,816	2,766	48,843	8,879	18.2	60,252	8,534	3,022	48,696	7,462	15.3
739	Yakima, WA	257,167	33,826	11,969	211,371	34,006	16.1	259,193	36,713	13,001	209,479	36,213	17.3
747	Wentachee, WA	231,928	30,507	10,795	190,627	60,685	31.8	234,062	33,153	11,740	189,169	60,073	31.8
748	Klickitat-Skamania Counties	29,292	3,853	1,363	24,076	2,239	9.3	29,430	4,169	1,476	23,785	2,249	9.5
784	Whitman County	40,375	5,311	1,879	33,185	7,246	21.8	40,631	5,755	2,038	32,838	8,990	27.4
Western Washington													
689	Vancouver-Kelso, WA	456,858	60,093	21,264	375,502	14,061	3.7 %	468,543	66,366	23,501	378,676	15,874	4.2 %
736	Seattle, WA	2,570,708	338,137	119,648	2,112,923	295,091	14.0	2,590,072	366,866	129,914	2,093,293	294,313	14.1
758	Olympia, WA	370,891	48,785	17,262	304,844	45,871	15.0	376,599	53,343	18,890	304,367	40,358	13.3
762	Bremerton-Silverdale, WA	283,123	37,240	13,177	232,705	22,797	9.8	287,182	40,677	14,405	232,100	13,724	5.9
785	Clallam-Jefferson Counties	91,771	12,071	4,271	75,429	9,889	13.1	93,063	13,182	4,668	75,213	8,822	11.7
794	Tacoma, WA	718,918	94,563	33,461	590,895	69,392	11.7	732,282	103,723	36,730	591,829	59,485	10.1
815	Bellingham, WA	170,673	22,449	7,944	140,280	15,747	11.2	174,362	24,697	8,746	140,919	16,546	11.7

Note: Premera's enrollment figures exclude Medicare Supplement and self-insured members.

Sources: Cols. (1), (7): U.S. Census Bureau, "Washington County Population Estimates: April 1, 2000 to July 1, 2002."
Cols. (2)-(3), (8)-(9): U.S. Census Bureau, "Table HI-4, Health Insurance Coverage Status and Type of Coverage by State, All People: 1987 to 2002."
Cols. (5), (11): 2001 and revised 2002 Premera Form B filings.

Table B-6

Premera's Estimated Share of the Total Purchases of Provider Services
By Metropolitan Statistical Area (MSA)
2001 - 2002

MSA	2001 Total Population	2001 Uninsured Population	2001 Covered by Military	2001 Insured Population	2001 Premera's Enrollment	2001 Premera's Estimated Share	2002 Total Population	2002 Uninsured Population	2002 Covered by Military	2002 Insured Population	2002 Premera's Enrollment	2002 Premera's Estimated Share
				(1) - [(2) + (3)]		(5) / (4)				(7) - [(8) + (9)]		(11) / (10)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Eastern Washington												
Kennewick-Richland-Pasco, WA	196,659	25,867	9,153	161,638	43,805	27.1 %	203,111	28,769	10,188	164,154	41,833	25.5 %
Lewiston, ID-WA	20,446	2,689	952	16,805	1,754	10.4	20,453	2,897	1,026	16,530	1,707	10.3
Spokane, WA	423,037	55,644	19,689	347,704	93,737	27.0	427,506	60,553	21,443	345,510	93,313	27.0
Wentachee, WA	99,795	13,126	4,645	82,024	27,935	34.1	100,459	14,229	5,039	81,191	26,553	32.7
Yakima, WA	223,366	29,380	10,396	183,590	26,327	14.3	224,823	31,845	11,277	181,702	27,479	15.1
Western Washington												
Bellingham, WA	170,673	22,449	7,944	140,280	15,747	11.2 %	174,362	24,697	8,746	140,919	16,546	11.7 %
Bremerton-Silverdale, WA	232,898	30,634	10,840	191,424	19,046	9.9	236,174	33,452	11,846	190,876	10,548	5.5
Longview-Kelso, WA	93,752	12,332	4,363	77,057	4,566	5.9	94,514	13,387	4,741	76,386	4,925	6.4
Mt. Vernon-Anacortes, WA	105,236	13,842	4,898	86,496	7,657	8.9	106,906	15,142	5,362	86,401	8,830	10.2
Olympia, WA	212,831	27,995	9,906	174,931	24,941	14.3	217,641	30,827	10,917	175,897	20,422	11.6
Portland-Vancouver-Beaverton, OR-WA	369,328	48,579	17,190	303,559	9,850	3.2	380,285	53,865	19,074	307,346	10,933	3.6
Seattle-Tacoma-Bellevue, WA	3,096,709	407,324	144,130	2,545,255	350,315	13.8	3,125,833	442,753	156,786	2,526,294	337,708	13.4

Note: Premera enrollment figures exclude Medicare Supplement and self-insured members.

Sources: Cols. (1), (7): U.S. Census Bureau, "Washington County Population Estimates: April 1, 2000 to July 1, 2002."
Cols. (2)-(3), (8)-(9): U.S. Census Bureau, "Table HI-4, Health Insurance Coverage Status and Type of Coverage by State, All People: 1987 to 2002."
Cols. (5), (11): 2001 and revised 2002 Premera Form B filings.

Table B-7

Premera's Estimated Share of the Total Purchases of Provider Services
By County
2001 - 2002

County	2001 Total Population	2001 Uninsured Population	2001 Covered by Military	2001 Insured Population	2001 Premera's Enrollment	2001 Premera's Estimated Share	2002 Total Population	2002 Uninsured Population	2002 Covered by Military	2002 Insured Population	2002 Premera Enrollment's	2002 Premera's Estimated Share
	(1)	(2)	(3)	(1) - [(2) + (3)] (4)	(5)	(5) / (4) (6)	(7)	(8)	(9)	(7) - [(8) + (9)] (10)	(11)	(11) / (10) (12)
Eastern Washington												
Adams	16,318	2,146	759	13,412	3,684	27.5 %	16,434	2,328	824	13,282	4,488	33.8 %
Asotin	20,446	2,689	952	16,805	1,754	10.4	20,453	2,897	1,026	16,530	1,707	10.3
Benton	145,857	19,185	6,789	119,883	34,288	28.6	150,366	21,298	7,542	121,526	32,292	26.6
Chelan	66,832	8,791	3,111	54,931	21,852	39.8	67,050	9,497	3,363	54,190	21,537	39.7
Columbia	4,068	535	189	3,344	592	17.7	4,103	581	206	3,316	501	15.1
Douglas	32,963	4,336	1,534	27,093	6,083	22.5	33,409	4,732	1,676	27,001	5,016	18.6
Ferry	7,290	959	339	5,992	1,093	18.2	7,268	1,029	365	5,874	1,494	25.4
Franklin	50,802	6,682	2,364	41,755	9,517	22.8	52,745	7,471	2,646	42,628	9,541	22.4
Garfield	2,350	309	109	1,932	649	33.6	2,327	330	117	1,881	578	30.7
Grant	76,512	10,064	3,561	62,887	20,014	31.8	77,983	11,046	3,911	63,026	20,684	32.8
Kittitas	33,801	4,446	1,573	27,782	7,679	27.6	34,370	4,868	1,724	27,778	8,734	31.4
Klickitat	19,301	2,539	898	15,864	1,714	10.8	19,381	2,745	972	15,664	1,947	12.4
Lincoln	10,141	1,334	472	8,335	3,529	42.3	10,096	1,430	506	8,160	4,236	51.9
Okanogan	39,303	5,170	1,829	32,304	9,052	28.0	39,186	5,550	1,966	31,670	8,348	26.4
Pend Oreille	11,861	1,560	552	9,749	3,225	33.1	12,008	1,701	602	9,705	2,839	29.3
Spokane	423,037	55,644	19,689	347,704	93,737	27.0	427,506	60,553	21,443	345,510	93,313	27.0
Stevens	40,477	5,324	1,884	33,269	8,302	25.0	40,556	5,744	2,034	32,777	8,446	25.8
Walla Walla	55,357	7,281	2,576	45,499	8,287	18.2	56,149	7,953	2,816	45,380	6,961	15.3
Whitman	40,375	5,311	1,879	33,185	7,246	21.8	40,631	5,755	2,038	32,838	8,990	27.4
Yakima	223,366	29,380	10,396	183,590	26,327	14.3	224,823	31,845	11,277	181,702	27,479	15.1
Total Eastern WA	1,320,457	173,686	61,458	1,085,313	268,624	24.8 %	1,336,844	189,355	67,054	1,080,435	269,131	24.9 %
Western Washington												
Clallam	65,304	8,590	3,039	53,675	8,090	15.1 %	66,302	9,391	3,326	53,585	6,920	12.9 %
Clark	359,337	47,265	16,725	295,347	9,325	3.2	370,236	52,441	18,570	299,224	10,631	3.6
Cowlitz	93,752	12,332	4,363	77,057	4,566	5.9	94,514	13,387	4,741	76,386	4,925	6.4
Grays Harbor	68,233	8,975	3,176	56,082	9,242	16.5	68,470	9,698	3,434	55,337	8,883	16.1
Island	73,348	9,648	3,414	60,286	5,678	9.4	75,050	10,630	3,764	60,655	6,250	10.3
Jefferson	26,467	3,481	1,232	21,754	1,799	8.3	26,761	3,791	1,342	21,628	1,902	8.8
King	1,753,901	230,699	81,632	1,441,571	215,663	15.0	1,759,604	249,236	88,259	1,422,110	214,926	15.1
Kitsap	232,898	30,634	10,840	191,424	19,046	9.9	236,174	33,452	11,846	190,876	10,548	5.5
Lewis	69,061	9,084	3,214	56,763	7,783	13.7	69,710	9,874	3,497	56,340	7,043	12.5
Mason	50,225	6,606	2,338	41,281	3,751	9.1	51,008	7,225	2,558	41,225	3,176	7.7
Pacific	20,766	2,731	967	17,068	3,905	22.9	20,778	2,943	1,042	16,793	4,010	23.9
Pierce	718,918	94,563	33,461	590,895	69,392	11.7	732,282	103,723	36,730	591,829	59,485	10.1
San Juan	14,333	1,885	667	11,781	833	7.1	14,565	2,063	731	11,771	1,010	8.6
Skagit	105,236	13,842	4,898	86,496	7,657	8.9	106,906	15,142	5,362	86,401	8,830	10.2
Skamania	9,991	1,314	465	8,212	525	6.4	10,049	1,423	504	8,122	302	3.7
Snohomish	623,890	82,063	29,038	512,789	65,260	12.7	633,947	89,794	31,798	512,355	63,297	12.4
Thurston	212,831	27,995	9,906	174,931	24,941	14.3	217,641	30,827	10,917	175,897	20,422	11.6
Wahkiakum	3,769	496	175	3,098	170	5.5	3,793	537	190	3,065	318	10.4
Whatcom	170,673	22,449	7,944	140,280	15,747	11.2	174,362	24,697	8,746	140,919	16,546	11.7
Total Western WA	4,672,933	614,652	217,492	3,840,788	473,373	12.3 %	4,732,152	670,276	237,357	3,824,519	449,424	11.8 %

Note: Premera's enrollment figures exclude Medicare Supplement and self-insured members.

Sources: Cols. (1), (7 U.S. Census Bureau, "Washington County Population Estimates: April 1, 2000 to July 1, 2002."
Cols. (2)-(3)U.S. Census Bureau, "Table HI-4, Health Insurance Coverage Status and Type of Coverage by State, All People: 1987 to 2002."
Cols. (5), (1 2001 and revised 2002 Premera Form B filings.

Privileged and Confidential
Prepared at Request of Counsel

Number of PCPs and Specialists by County in Eastern Washington
1994 - 2002

	PCPs									Specialists								
County	1994	1995	1996	1997	1998	1999	2000	2001	2002	1994	1995	1996	1997	1998	1999	2000	2001	2002
Adams	9	9	9	6	8	8	7	7	9	4	5	6	4	4	5	5	5	4
Asotin	7	8	8	8	7	8	11	12	13	16	13	13	17	17	16	18	20	21
Benton	52	61	63	71	70	72	79	79	79	130	126	143	158	164	162	163	178	181
Chelan	47	50	56	61	62	67	62	58	62	107	112	124	129	130	129	130	138	138
Columbia	2	2	2	2	2	2	3	3	4	1	1	1	1	1	1	1	-	-
Douglas	5	4	5	4	5	5	12	12	12	5	3	3	3	4	3	5	6	3
Ferry	3	2	3	3	2	2	1	1	1	2	2	2	2	2	2	3	2	2
Franklin	15	17	19	20	21	21	20	20	23	21	25	28	24	25	26	25	24	28
Garfield	-	-	1	2	1	1	1	1	1	1	1	-	-	-	-	1	1	1
Grant	26	30	29	30	29	31	35	40	39	29	27	28	32	33	30	31	38	37
Kittitas	20	19	17	20	18	21	21	19	21	14	14	16	13	15	15	13	13	12
Klickitat	10	9	11	11	12	11	15	15	15	3	2	2	2	2	3	3	3	3
Lincoln	6	5	6	6	6	6	6	6	6	1	1	3	3	3	3	3	3	3
Okanogan	27	29	29	32	30	33	35	37	37	12	14	16	17	17	12	13	15	16
Pend Oreille	4	6	5	5	5	5	4	5	5	-	-	-	1	1	1	2	2	2
Spokane	298	299	298	313	329	334	340	340	366	637	647	669	677	682	676	689	729	761
Stevens	23	24	23	23	21	23	27	30	27	13	12	14	15	17	15	13	15	16
Walla Walla	32	29	39	41	40	39	42	50	51	86	87	87	90	94	90	99	97	107
Whitman	23	23	24	27	26	26	24	27	28	19	19	21	21	22	20	24	26	25
Yakima	126	126	139	146	145	151	143	147	155	191	191	195	214	211	215	217	231	235
Total	**735**	**752**	**786**	**831**	**839**	**866**	**888**	**909**	**954**	**1,292**	**1,302**	**1,371**	**1,423**	**1,444**	**1,424**	**1,458**	**1,546**	**1,595**

Note: PCPs include Family Practice, General Practice, and Internal Medicine. Specialists include all other physicians.

Source: AMA Physician Count, 1994 - 2002.

Table B-9

Summary of Results for Physician Reimbursement Regressions Based on Medicare RBRVS Percentage

Dependent Variable: Medicare RBRVS Percentage

Coefficients / (t-statistics)

	Regression Results			
Explanatory Variable	**By Region**	**By HSA**	**By MSA**	**By County**
Constant	PROPRIETARY MATERIAL REDACTED			
Eastern WA Dummy Variable				
R-Square				
F-Statistic				
Observations				

* Significant at 5 percent level.
** Significant at 1 percent level.

Note: This is a fixed effects regression model. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

Table B-10

Summary of Results for Physician Reimbursement Regressions Based on Medicare RBRVS Percentage Sensitivity Test - Region Level

Dependent Variable: Medicare RBRVS Percentage

Explanatory Variable	Coefficient / (t-statistic)
Constant	PROPRIETARY MATERIAL REDACTED
Region Dummy Variable:	
Eastern WA Rural	
Eastern WA Urban	
Western WA Rural	
Western WA Urban	
R-Square	
F-Statistic	
Observations	

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: This is a fixed effects regression model. King County / Seatte is the omitted area and is controlled for by the constant. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

Table B-11

Summary of Results for Physician Reimbursement Regressions Based on Medicare RBRVS Percentage Sensitivity Test - HSA Level

Dependent Variable: Medicare RBRVS Percentage

Explanatory Variable	Coefficient / (t-statistic)
Constant	
HSA Dummy Variable:	
Eastern Washington	
694 Asotin-Garfield Counties	
717 Columbia-Walla Walla Counties	
702 Kennewick-Richland-Pasco, WA	
748 Klickitat-Skamania Counties	
698 Spokane, WA	
747 Wentachee, WA	
784 Whitman County	
739 Yakima, WA	
Western Washington	
815 Bellingham, WA	
762 Bremerton-Silverdale, WA	
785 Clallam-Jefferson Counties	
758 Olympia, WA	
794 Tacoma, WA	
689 Vancouver-Kelso, WA	
R-Square	
F-Statistic	
Observations	

PROPRIETARY MATERIAL REDACTED

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: This is a fixed effects regression model. King County / Seatte is the omitted area and is controlled for by the constant. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

Table B-12

Summary of Results for Physician Reimbursement Regressions Based on Medicare RBRVS Percentage Sensitivity Test - MSA Level

Dependent Variable: Medicare RBRVS Percentage

Explanatory Variable	Coefficient / (t-statistic)
Constant	
MSA Dummy Variable:	
Eastern Washington	
Kennewick-Richland-Pasco, WA	
Lewiston, ID-WA	
Spokane, WA	
Wentachee, WA	
Yakima, WA	
Western Washington	
Bellingham, WA	
Bremerton-Silverdale, WA	
Longview-Kelso, WA	
Mt. Vernon-Anacortes, WA	
Olympia, WA	
Portland-Vancouver-Beaverton, OR-WA	
R-Square	
F-Statistic	
Observations	

PROPRIETARY MATERIAL REDACTED

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: This is a fixed effects regression model. King County / Seatte is the omitted area and is controlled for by the constant. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

Summary of Results for Physician Reimbursement Regressions
Based on Medicare RBRVS Percentage
Sensitivity Test - County Level

Dependent Variable: Medicare RBRVS Percentage

Explanatory Variable	Coefficient	(t-statistic)
Constant		
County Dummy Variable:		
Eastern Washington		
Adams		
Asotin		
Benton		
Chelan		
Columbia		
Douglas		
Ferry		
Franklin		
Garfield		
Grant		
Klickitat		
Lincoln		
Okanogan		
Pend Oreille		
Spokane		
Stevens		
Walla Walla		
Whitman		
Yakima		
Western Washington		
Clallam		
Clark		
Cowlitz		
Grays Harbor		
Island		
Jefferson		
Kitsap		
Lewis		
Mason		
Pacific		
Pierce		
San Juan		
Skagit		
Skamania		
Snohomish		
Thurston		
Wahkiakum		
Whatcom		
R-Square		
F-Statistic		
Observations		

PROPRIETARY MATERIAL REDACTED

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: This is a fixed effects regression model. King County / Seattle is the omitted area and is controlled for by the constant. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

Kittitas County had no claims.

Summary of Results for Physician Reimbursement Regressions Based on Allowed Amount Per Claim Sensitivity Test - Region Level

Dependent Variable: Allowed Amount per Claim

Explanatory Variable	Coefficient / (t-statistic)
Constant	
RVUs per Claim	
Region Dummy Variable:	
Eastern WA Rural	
Eastern WA Urban	
Western WA Rural	
Western WA Urban	
R-Square	
F-Statistic	
Observations	

PROPRIETARY MATERIAL REDACTED

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: This is a fixed effects regression model. King County / Seatte is the omitted area and is controlled for by the constant. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

Summary of Results for Physician Reimbursement Regressions Based on Allowed Amount Per Claim Sensitivity Test - HSA Level

Dependent Variable: Allowed Amount per Claim

Explanatory Variable	Coefficient / (t-statistic)
Constant	
HSA Dummy Variable:	
Eastern Washington	
694 Asotin-Garfield Counties	
717 Columbia-Walla Walla Counties	
702 Kennewick-Richland-Pasco, WA	
748 Klickitat-Skamania Counties	
698 Spokane, WA	
747 Wentachee, WA	
784 Whitman County	
739 Yakima, WA	
Western Washington	
815 Bellingham, WA	
762 Bremerton-Silverdale, WA	
785 Clallam-Jefferson Counties	
758 Olympia, WA	
794 Tacoma, WA	
689 Vancouver-Kelso, WA	
R-Square	
F-Statistic	
Observations	

PROPRIETARY MATERIAL REDACTED

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: This is a fixed effects regression model. King County / Seatte is the omitted area and is controlled for by the constant. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

Table B-16

Summary of Results for Physician Reimbursement Regressions Based on Allowed Amount Per Claim Sensitivity Test - MSA Level

Dependent Variable: Allowed Amount per Claim

Explanatory Variable	Coefficient / (t-statistic)
Constant	PROPRIETARY MATERIAL REDACTED
MSA Dummy Variable:	
Eastern Washington	
Kennewick-Richland-Pasco, WA	
Lewiston, ID-WA	
Spokane, WA	
Wentachee, WA	
Yakima, WA	
Western Washington	
Bellingham, WA	
Bremerton-Silverdale, WA	
Longview-Kelso, WA	
Mt. Vernon-Anacortes, WA	
Olympia, WA	
Portland-Vancouver-Beaverton, OR-WA	
R-Square	
F-Statistic	
Observations	

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: This is a fixed effects regression model. King County / Seatte is the omitted area and is controlled for by the constant. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

Summary of Results for Physician Reimbursement Regressions Based on Allowed Amount Per Claim Sensitivity Test - County Level

Dependent Variable: Allowed Amount per Claim

Coefficients / (t-statistics)

Explanatory Variable	Coefficient	(t-statistic)
Constant		
County Dummy Variable:		
Eastern Washington		
Adams		
Asotin		
Benton		
Chelan		
Columbia		
Douglas		
Ferry		
Franklin		
Garfield		
Grant		
Klickitat		
Lincoln		
Okanogan		
Pend Oreille		
Spokane		
Stevens		
Walla Walla		
Whitman		
Yakima		
Western Washington		
Clallam		
Clark		
Cowlitz		
Grays Harbor		
Island		
Jefferson		
Kitsap		
Lewis		
Mason		
Pacific		
Pierce		
San Juan		
Skagit		
Skamania		
Snohomish		
Thurston		
Wahkiakum		
Whatcom		
R-Square		
F-Statistic		
Observations		

PROPRIETARY MATERIAL REDACTED

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: This is a fixed effects regression model. King County / Seatte is the omitted area and is controlled for by the constant. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

Kittitas County had no claims.

Table B-18

Summary of Results for Physician Reimbursement Regressions Based on Top 25 CPT Codes

Dependent Variable: Allowed Amount per Claim

Coefficients / (t-statistics)

	Regression Results	
Explanatory Variable	**By Region**	**By County**
Constant	PROPRIETARY MATERIAL REDACTED	
Area Adjustment Factor		
Eastern WA Dummy Variable		
R-Square		
F-Statistic		
Observations		

* Significant at 5 percent level.
** Significant at 1 percent level.

Note: This is a fixed effects regression model. The results for the 24 CPT code dummy variables are not shown due to space limitations.

Table B-19

Summary of Results for Physician Reimbursement Regressions Based on Top 25 CPT Codes Sensitivity Test - Region Level

Dependent Variable: Allowed Amount per Claim

Explanatory Variable	Coefficient / (t-statistic)
Constant	
Region Dummy Variable:	
Eastern WA Rural	
Eastern WA Urban	
Western WA Rural	
Western WA Urban	
R-Square	
F-Statistic	
Observations	

PROPRIETARY MATERIAL REDACTED

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: This is a fixed effects regression model. King County / Seatte is the omitted area and is controlled for by the constant. The results for the 24 CPT code dummy variables are not shown due to space limitations.

Table B-20

Summary of Results for Physician Reimbursement Regressions
Based on Top 25 CPT Codes
Sensitivity Test - County Level

Dependent Variable: Allowed Amount per Claim

Coefficients / (t-statistics)

Explanatory Variable	Coefficient	(t-statistic)
Constant	PROPRIETARY MATERIAL REDACTED	
County Dummy Variable:		
Eastern Washington		
Adams		
Asotin		
Benton		
Chelan		
Columbia		
Douglas		
Ferry		
Franklin		
Garfield		
Grant		
Klickitat		
Lincoln		
Okanogan		
Pend Oreille		
Spokane		
Stevens		
Walla Walla		
Whitman		
Yakima		
Western Washington:		
Clallam		
Clark		
Cowlitz		
Grays Harbor		
Island		
Jefferson		
Kitsap		
Lewis		
Mason		
Pacific		
Pierce		
San Juan		
Skagit		
Skamania		
Snohomish		
Thurston		
Wahkiakum		
Whatcom		
R-Square		
F-Statistic		
Observations		

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: This is a fixed effects regression model. King County / Seatte is the omitted area and is controlled for by the constant. The results for the 24 CPT code dummy variables are not shown due to space limitations.

Kittitas County had no claims.

Replication and Revision of Dr. Leffler's PCP Regression for Total Groups Sensitivity Test

Regression Results

Coefficients / (t-statistics)

Dependent Variable:	**Paid Amount per Claim**		**Allowed Amount per Claim**	
Explanatory Variable	**Replication**	**Controlled for Intensity of Services**	**Replaced Paid Amounts with Allowed Amounts**	**Controlled for Additional Specialities[1]**
Constant				
Combined Share				
Area Adjustment Factor		PROPRIETARY MATERIAL REDACTED		
RVUs per Claim				
R-Square				
F-Statistic				
Observations				

* Significant at 5 percent level.
** Significant at 1 percent level.

Notes: PCPs are defined as Family Practice, General Practice and Internal Medicine.
"na" indicates not applicable.

[1] This is a fixed effects regression model. The results for the 46 physician specialty dummy variables are not shown due to space limitations.

Table B-22

Summary of Results for Not-For-Profit Regressions
Sensitivity Test

Dependent Variable: Premiums per Member

Coefficients / (t-statistics)

	Plan Regressions	
Explanatory Variable	**Year Dummies**	**Time Trend**
Constant	PROPRIETARY MATERIAL REDACTED	
Medical Expenses per Member		
HMO Membership Percent		
Medicare Managed Care Membership Percent		
Medicaid Managed Care Membership Percent		
Medicare Supplement Membership Percent		
Not-For-Profit Dummy Variable		
R-Square		
F-Statistic		
Observations		

* Significant at 5 percent level.
** Significant at 1 percent level.

Note: Results are based on excluding 1997 - 1999 data since the Medicare Supplement information is not available for that period.

Figure B-1

Health Service Areas (HSAs) in Eastern and Western Washington

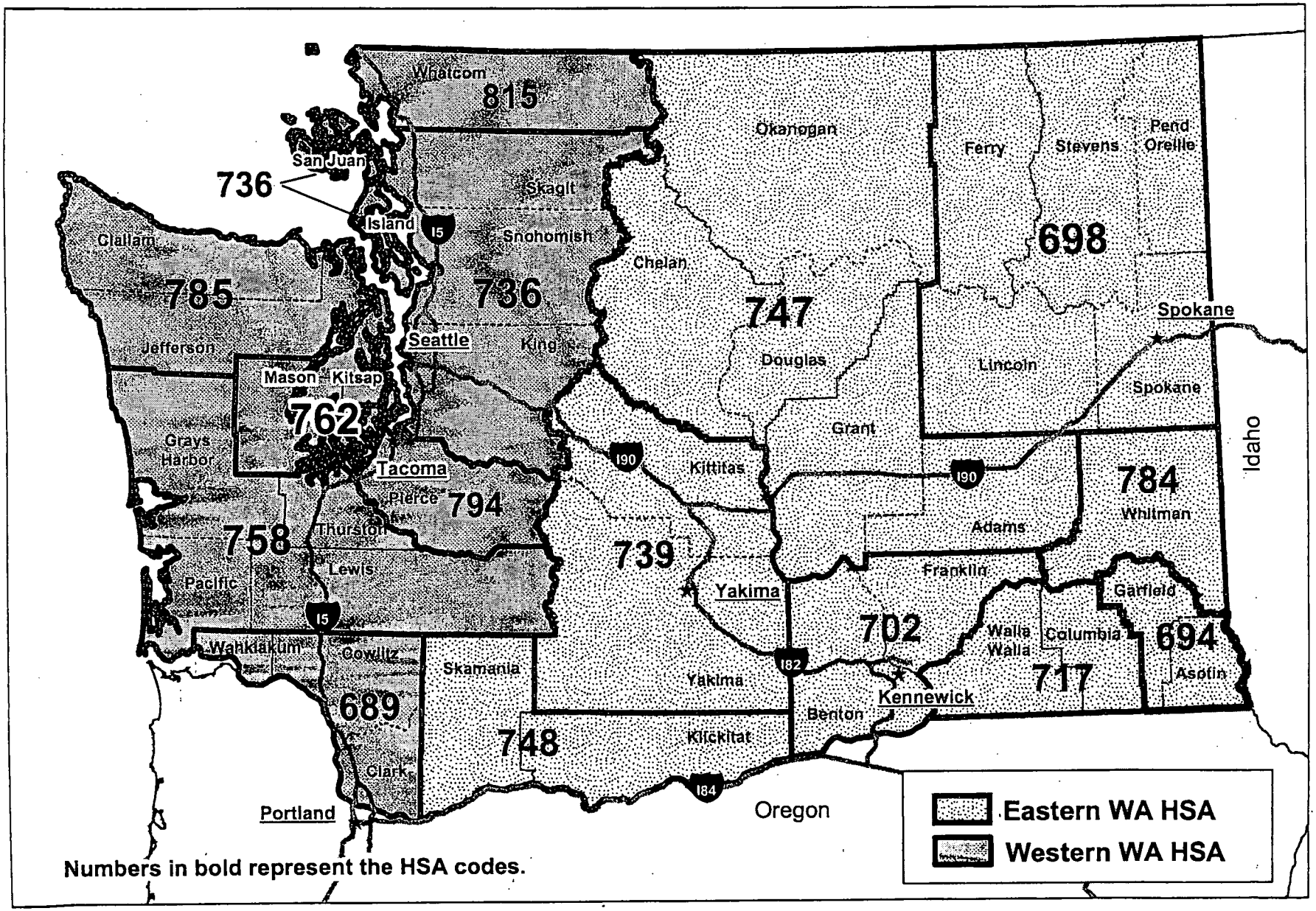
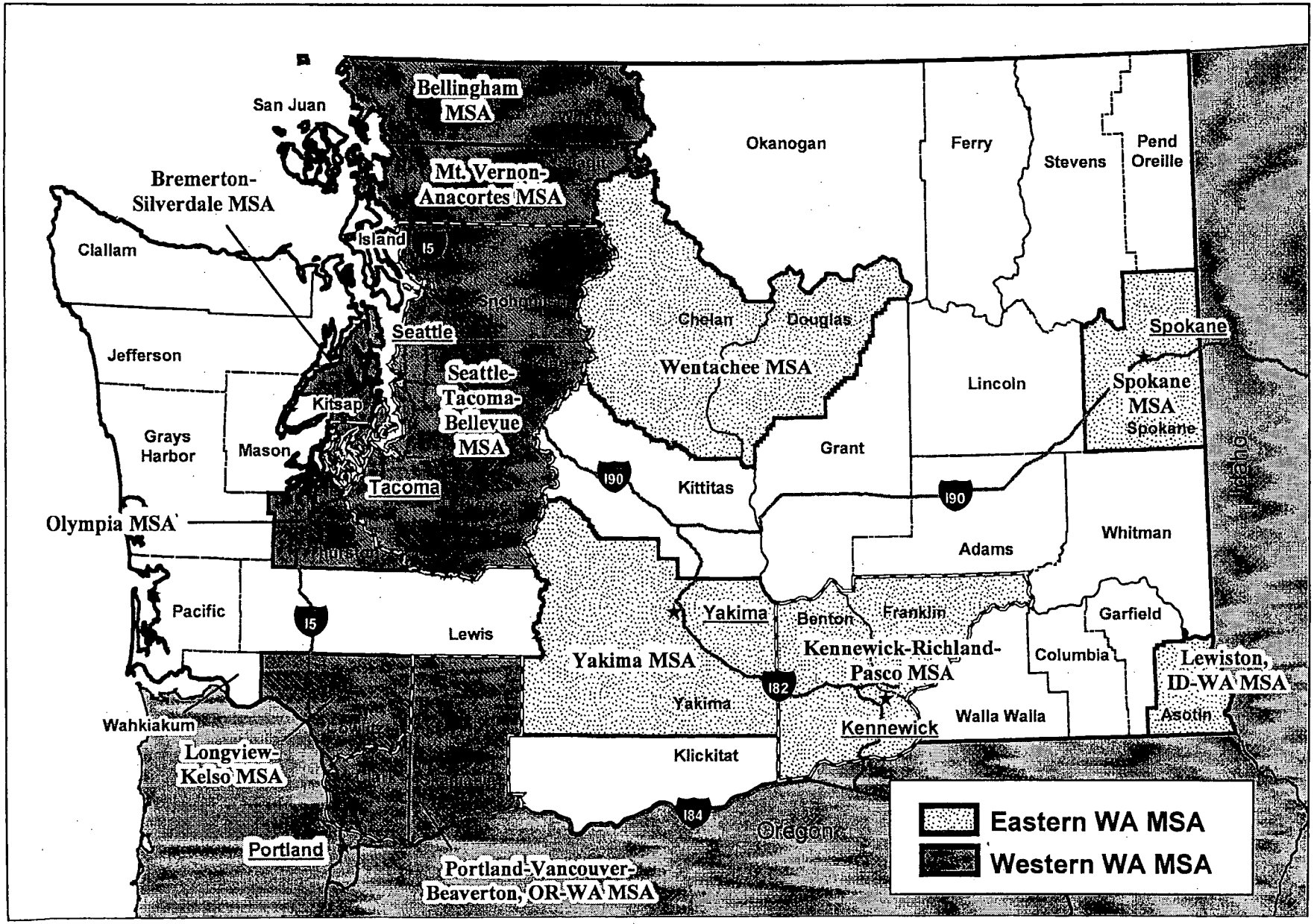


Figure B-2

Metropolitan Statistical Areas (MSAs) in Eastern and Western Washington



NERA
Economic Consulting

National Economic Research Associates, Inc.
777 South Figueroa Street, Suite 4200
Los Angeles, CA 90017
213 346 3000

MMC Marsh & McLennan Companies